Financial Agreement

972.608.4746
972.608.4749 fax

Thank you for choosing us for your child's dental care. Dr. Ryan and the staff of Grin Pediatric Dentistry have been specially trained to provide comprehensive dental care for your child(ren) in a fun and educational environment. To eliminate any confusion or miscommunication regarding your account and financial obligation, we ask that you read, understand and agree to the following terms and conditions:

- **Insurance:** Your dental insurance coverage is a contract between you, your insurance provider, and, in most cases, your employer. ***Please note our office is OUT-OF-NETWORK with most insurance companies. However, we are IN-NETWORK WITH SELECTED INSURANCE COMPANIES.*** As a courtesy to you, we will file to your insurance company. However, any co-insurance will be due in full at the time of service. **We do not file any secondary insurance.** It is ***your responsibility*** to understand the terms of your insurance plan including but not limited to eligibility, covered benefits, deductibles and maximums. You are responsible for any and all charges not covered by your insurance company.
  _____(Initials)

- **Missed Appointments:** Appointments are reserved in advance for your child(ren). We require that you give us a 24-hour advance notification for any scheduling change, because your child's individual appointment time with the Doctor impacts the medical and dental health of our other patients. Missed appointments will be charged at the rate of **$50.00**. _____(Initials)

- **Returned Checks:** If your check is returned to us for non-sufficient funds payment in full of all balances including bank fees will be due immediately. Please be advised that accepting future checks for your payment will be at the discretion of Dr. Ryan. _____(Initials)

- **Divorce:** In the case of divorce or separation, the **parent requesting treatment** for the child will be held accountable for any charges for services rendered, regardless of a divorce decree. It is not the responsibility of Dr. Ryan to figure out which parent is responsible for what payments. If your divorce decree requires the other parent to pay all or part of the treatment costs, it is the **requesting parent's** responsibility to collect from the other parent after settling their account with Grin Central Station LLP/ Grin Pediatric Dentistry.
  _____(Initials)

I have read and fully understand my financial obligation and the financial policies of Grin Central Station/Grin Pediatric Dentistry. I agree to be bound by its terms. I also understand and agree that such terms may be amended periodically as needed by the practice.

_____ _____
Signature of Responsible Party Date

_____
Please Print Name of the Signature Above

Patient Consent Form

grin PEDIATRIC DENTISTRY

972.608.4746
972.608.4749 fax

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this form can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare provides who may be involved in that treatment directly and indirectly
- Obtain payment from third- party payers
- Conduct normal healthcare operations such as quality assessments and physician certification

I have been informed by the organization of their *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information have informed me. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at anytime, except to the extent that you have taken relying on this consent.

Patient(s) Name(s): _____

Legal Guardian Signature: _____

Relationship to Patient(s): _____

Date: _____

Patient Information and Medical History

972.608.4746
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Child Legal Name: _____ Preferred Name: _____

Date of Birth _____/_____/_____ Age: _____ Weight: _____ ☐ Male ☐ Female

Home Address: _____ Apt. # _____

City: _____ State: _____ Zip code: _____

School: _____ District: _____ Grade: _____

Have sibling(s) been seen in this office? ☐ Yes ☐ No

Name(s) of sibling(s): _____

***WHOM MAY WE THANK FOR REFERRING YOU TO US?**

☐ Pediatrician/Doctor ☐ Friend

☐ Internet ☐ Other

Name: _____

EMERGENCY CONTACT (other than parents)

Name: _____

Relationship: _____

Phone #: _____

HEALTH PROVIDER

Child's Physician/Pediatrician: _____ Phone #_____

Mailing Address: _____City: _____ State: _____ Zip: _____

DENTAL HISTORY

What is the reason for your child's dental visit? _____

Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) _____

Name of previous dentist: _____ Phone: _____

☐Yes ☐No Has your child experienced any unfavorable reaction from previous dental care?
Explain:_____

☐Yes ☐No Does your child suck a finger, thumb, or pacifier?

☐Yes ☐No Does your child have pain when chewing, yawning, or wide opening?

☐Yes ☐No Does your child go to bed with a bottle or sippy cup?

☐Yes ☐No Does your child snack frequently? What are their favorite snack(s) foods? _____

☐Yes ☐No Has your child had local anesthetic? Were there any problems? _____

☐Yes ☐No Has your child been sedated for dental treatment? Were there any problems?
Explain (if yes) _____

☐Yes ☐No Have your child's teeth ever been injured? Which teeth: _____
Dental treatment for trauma: _____

Please check if your child is having problems with the following:

☐Cavities ☐Toothache ☐Sensitive Teeth ☐Mouth Breathing ☐Trauma
☐Gum Infections ☐Color of Teeth ☐Jaw Sounds ☐Grinding of Teeth

Comments:

_____

Patient Information and Medical History

972.608.4746
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MEDICAL HISTORY

Is your child allergic to:

☐ Penicillin ☐ Latex ☐ Aspirin ☐ Local Anesthetic (Lidocaine)
☐ Foods: _____ ☐ Other (including OTC)_____

☐ Yes ☐ No Is your child in good health? Date of last physical exam _____
☐ Yes ☐ No Has your child ever had a health problem? _____
☐ Yes ☐ No Are your child's immunizations current?
☐ Yes ☐ No Is your child currently taking any medications? Please list medication, dose & reason:
_____
☐ Yes ☐ No Have you ever been told that your child needs to take antibiotics before dental treatment?
☐ Yes ☐ No Has your child ever been hospitalized, had general anesthesia, or emergency room visits?
Explain: _____

Do you consider your child to be:

☐ advanced in the learning process
☐ progressing normally
☐ slow in the learning process

Please check if your child has been treated for any of the following:

☐ Abuse	☐ Cancer/Tumors	☐ Heart Murmur	☐ Recurrent herpes/fever blisters
☐ ADD/ADHA	☐ Cerebral palsy	☐ Hepatitis	☐ Rheumatic fever
☐ AIDS	☐ Cleft lip/palate	☐ Kidney Disease	☐ Seizures
☐ Anemia	☐ Congenial birth defects	☐ Liver/GI Disease	☐ Sickle cell disease/trait
☐ Anxiety Disorder	☐ Diabetes	☐ Mental Delays	☐ Significant Injuries
☐ Arthritis	☐ Endocrine	☐ Personality Disorder	☐ Snoring
☐ Asthma/Breathing	☐ Eyesight	☐ Social Disorder	☐ Speech/Hearing
☐ Autism	☐ Frequent Infections	☐ Physical Delays	☐ Tonsil/Adenoid Problems
☐ Bleeding/transfusions	☐ Heart Disease	☐ Recurrent Headaches	☐ Tuberculosis

Other:

_____

If any boxes checked, please describe further:

_____

CONSENT FOR DENTAL TREATMENT

I certify that I have read and understand the above information on this form to the best of my knowledge. All questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I also understand it is very important to report any changes in my child's medical or dental status to the dentist at the earliest possible time, and I agree to do so.

I give consent for Grin Central Station LLP to perform dental treatment on my child.

I understand I will be responsible for any charges incurred for my child for dental treatment.

Signature _____ Date _____

Relationship to Patient: _____

Family and Insurance Information

972.608.4746
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Parent/Legal Guardian 1: _____ Relationship to Patient _____

Date of Birth _____/_____/_____ Social Security _____-_____-_____

Cell Phone # _____ Work Phone # _____

Email _____

Address (if different from child's) _____

_____

Occupation _____ Employer _____

Parent/Legal Guardian 2: _____ Relationship to Patient _____

Date of Birth _____/_____/_____ Social Security _____-_____-_____

Cell Phone # _____ Work Phone # _____

Email _____

Address (if different from child's) _____

_____

Occupation _____ Employer _____

Child's parents are ☐ Married ☐ Divorced ☐ Separated ☐ Other

DENTAL INSURANCE INFORMATION

Dental Insurance? ☐ Yes ☐ No

Policy Holder's Name _____ Date of Birth _____

Relationship to Patient _____

Employer Name _____

Dental Insurance Company Name _____

Policy Holder ID# or SS# _____ Group # _____

Insurance Phone _____

Insurance Mailing Address _____

____ (Initials) grin pediatric dentistry is **OUT-OF-NETWORK** with most insurance companies. However, we are **IN-NETWORK with SELECTED INSURANCE COMPANIES.** Please notify our office of any changes to your insurance coverage to confirm your network status.

____ (Initials) *Since this patient is a minor, it becomes necessary that a signed permission be obtained from the parent or legal guardian before any dental service can be performed. Authorization is hereby granted as such.*

____ (Initials) I understand I will be responsible for any charges incurred for my child for dental treatment.

Legal Guardian's Signature: _____Date: _____

Relationship to Patient: _____

Patient Information Authorization

972.608.4746
972.608.4749 fax

This form is to be completed for any other person bringing the child/children in for their dental appointments other than the natural mother or father or legal guardian.

Patient Name _____ Birthdate _____

Patient Name _____ Birthdate _____

Patient Name _____ Birthdate _____

Patient Name _____ Birthdate _____

Patient Name _____ Birthdate _____

I give Grin Central Station LLP permission to discuss the indicated aspects of my account with the following person(s).

(Please check all that apply)

___Can consent to (sign consent) and discuss recommended treatment

___Can schedule appointments

___Can discuss financial arrangements

___Can discuss information related to insurance coverage and payments

___Can discuss completed treatment

1. _____ _____
(Print name) (Relationship to patient)

2. _____ _____
(Print name) (Relationship to patient)

3. _____ _____
(Print name) (Relationship to patient)

Signature _____ Date _____
(Natural mother or father or legal guardian)

This authorization will remain in effect until it is revoked in writing by the natural mother, father, or legal guardian listed above.

Consent Form

Authorization to photograph

I hereby **GRANT / DENY** permission to Grin Pediatric Dentistry to use any photographs my child(ren), _____, may be included in.

Photographs may be taken during in-office parties, contests, theme days, and holidays.

I understand these photos may be used on Grin Pediatric Dentistry social media websites (facebook, etc.) and the Grin Pediatric Dentistry website.

I **GRANT / DENY** permission for these images to be used in this manner as deemed appropriate by Grin Pediatric Dentistry. I release all rights to all images created and prepared, and release Grin Pediatric Dentistry from any claims or liabilities.

I acknowledge the following statement:

I understand I may revoke this authorization at any time by notifying Grin Pediatric Dentistry in a form of writing to 6225 Chapel Hill Blvd Plano, TX 75093 or by email to appts@grin-dental.com. I understand that this revocation will not effect any actions previously taken by Grin Pediatric Dentistry.

_____ _____

Signature of legally authorized representative Date

Continuous Authorization

Grin Central Station LLP
972.608.4746

We kindly request that any balance arrangements be made **in advance**, with a **credit card kept on file** for your convenience.

I, _____, authorize Grin Pediatric Dentistry to retain my credit card on file as part of my dental records, for payment purposes only. After my dental insurance company has paid its portion of the dental services rendered to me at Grin Pediatric Dentistry. I, _____, hereby give my consent to Grin Pediatric Dentistry to charge any outstanding balance to my credit card on file. This balance may include deductibles, denials, and non-covered services.

I have been informed Grin Pediatric Dentistry will keep this signature on file for any estimated patient portion due at the time of services, and any outstanding balance after insurance payment. I understand that the amount owe provided on my treatment plan is only an estimate and my actual financial obligation may be higher than anticipated depending on my insurance plan.

I understand I have the right to change my credit card information at any time, and I must notify Grin Pediatric Dentistry in a timely manner. I understand this form is valid without expiration until I give a 30 day written notice of cancellation to Grin Pediatric Dentistry.

Courtesy Call Option

For any balances over **$30, would you like to receive a **courtesy call** before we process your card on file?*

_____*Yes* _____ *No*

If you opt to receive a courtesy call, we will notify you that there is a balance on your account and that your card on file is scheduled to be processed. If you would prefer the charge to be processed on a different day, please contact our office **within 24 hours** of the courtesy call. If we do not hear from you within that timeframe, we will proceed with processing the card as scheduled.

Credit Card Information:

_____Visa _____Mastercard _____Discover _____Amex

Card Holder's Name:_____

Card #:_____

Exp Date:_____ CVC:_____

Address:_____

Cell Phone #:_____

By signing below, I acknowledge that I have read and understand the above disclosure. I confirm that all information I have provided is accurate and complete. I agree to the terms outlined in the One Time Authorization above.

Responsible Party Name:_____ Relationship:_____

NOTICE OF PRIVACY PRACTICES

Elvebak Orthodontics &
Grin Pediatric Dentistry

Grin Central Station
6225 Chapel Hill Blvd
Plano, TX 75093
(972) 608-4746

17300 Preston Road, ste. 150
Dallas, TX 75252
(972) 608-4746

Privacy Officer: Vicky Warren

Effective Date: 09/11/2017

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical/ dental information. We make a record of the dental care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality dental care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this dental practice properly. 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. This notice describes how we may use and disclose your medical/ dental information. It also describes your rights and our legal obligations with respect to your medical/ dental information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Dental Practice May Use or Disclose Your Health Information

This dental practice collects health information about you and stores it in a chart [and/or on a computer][and in an electronic health record/personal health record]. This is your dental record. The dental record is the property of this dental practice, but the information in the dental record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical/ dental information about you to provide your dental care. We disclose medical/ dental information to our employees and others who are involved in providing the care you need. For example, we may share your medical/ dental information with other dentists or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical/ dental information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical/ dental information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical/ dental information about you to operate this dental practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your dental plan to authorize services or referrals. We may also use and disclose this information as necessary for dental reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical/ dental information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or dental plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review

of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical/ dental information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical/ dental information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation, which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical/ dental information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose

information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we may be required make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this dental practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another dentist or dental group.

19. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

20. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Dental Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this dental practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this dental practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical/ dental information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible,

or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this dental practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this dental practice, except that this dental practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this dental practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this dental practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region VI - Dallas (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)

Jorge Lozano, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

Voice Phone (800) 368-1019
FAX (214) 767-0432
TDD (800) 537-7697
OCRMail@hhs.gov

The complaint form may be found at
www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf

You will not be penalized in any way for filing a complaint.