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 medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ 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/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 ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ 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 Spells/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 Pacemaker ◯ 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? ◯ Yes ◯ No _____

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 (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 _____

TIME 3:57 PM DATE 8/14/2017

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Susan Haynes DMD
1795 AIRWAY AVENUE STE A,
KINGMAN AZ, 86409
Phone (928) 692-1100, Fax (928) 692-1114

Written Financial Policy

Thank you for choosing Let's C U Smile PLLC, Susan Haynes DMD. The following is our financial policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. Is you have any questions or concerns about our payment policies, please do not hesitate to ask our office manager. We ask that all patients read and sign our financial policy, complete our patient information and consent form prior to seeing the doctor. **Payments for services are due at the time services are rendered.**

Payment Options:

You can choose from:

- Cash or Check
- Visa, Mastercard or Discover Card
- Convenient Monthly Payment Plans[1] from CareCredit
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Susan Haynes DMD requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

- Your insurance policy is a contract between you, your employer and the insurance company. **We are not a party to that contract and cannot guarantee any payment by your insurance company.** Our relationship is with you not your insurance company.
- **All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services will not be covered.**

- Fees for these services, along with unpaid deductibles and co-payments are due at the end of treatment.
- However, if we do not receive payment from your insurance carrier within 45 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.
- Let's C U Smile charges $55 for returned checks.

PROFESSIONAL FEES, EXPENSES, COSTS. If any actions or proceeding is instituted to enforce any term of this agreement, the party prevailing in that action or proceeding shall be entitled to recover his/her/its reasonable attorney's fees, consultants' fees, Collection fees, also to recover his/her/its litigation expenses and court costs, as may be determined by the court.

We understand that temporary financial problems may affect the timely manner in which your balance is paid. We encourage you to communicate any such problems so that we can assist you in the management of your account. Again, thank you for choosing Let's C U Smile as your dental provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

If you have any questions, please so not hesitate to ask. We are here to help you get the dentistry you want or need.

X _____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

Cancellation Policy
Please initial each paragraph after reading it.

____: Our office hours are by appointment and we do value your time. Appointment times are reserved for you alone. When you make an appointment, please be sure that you will be able to keep it.

____: If you cannot make an appointment as scheduled, we require a 48 business hour notice so we can fill your appointment time with another patient. Missed appointments that are not given a 48 business hour advanced notice are subject to a $50.00 charge.

If you have any questions about our appointment cancellation or no show policy, please feel free to ask us.

Thank you.

Patient Signature Date

Signature Form

Health History- 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 responsiblity to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

_____ _____

Consent for Services- I have read the Consent for Services and payment and agree to their content.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

_____ _____

Privacy Practices- I acknowledge that I have read a copy of the Let's C U Smile Dentistry's Notice of Privacy Practices and that I may request a copy of this notice at any time.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

_____ _____

Referral Information- Whom may we thank for referring you to our practice?

__ Another patient, friend __ Another patient, relative __ Dental Office __ Yellow Pages

__ Newspaper __ School __ Work __ Other _____

Name of person referring you to our office _____

Consent for Services-

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment

All emergency dental services, or any dental services performed without previous arrangements, must be paid for in cash at the time of services.

A service charge and/or statement fee may be assessed on unpaid balances on all accounts extending 60 days.

I understand that the fee estimate listed for the dental care can only be extended for a period of 6 months from the date of the patient examination.

In consideration for the professsional services rendered to me, or at my request by the Doctor, I agree to pay the responsible value of said services to said Doctor, or their assignee, at the time said services are rendered or within five (5) days of billing if credit should be extended. I further agree that the responsible value of said services shall be as billed unless objected to, by me in writing within the time for payment thereof, I further agree that a waiver of any breech of any time or condition here under shall not constitute a waiver of any further term or condition and I further agree to pay all costs and responsible attorney fees if suit be instituted hereunder.

If at any time it becomes necessary to assign your outstanding balance due to an outside collection agency or attorney for collections of monies owed to Let's C U Smile, you the patient/guarantor agree to, in addition to the principle balance owed, pay all related collections and/or legal costs and fees.

I grant my permission to you or assignee, to telephone me at work or at my home to discuss matters related to this form.

Please sign Signature Form for your consent.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been given the opportunity to review the Let's C U Smile Dentistry's HIPPA Notice of Privacy Practices:

-It tells me how Let's C U Smile Dentistry will use my health information for the purposes of my treatment, payment for treatment and health care operations.

-The Notice also explains in more detail how Let's C U Smile Denistry may use and share my health information for other than treatment, payment and health care operations.

-Let's C U Smile Dentistry will also use and share my health information as required/permitted by law.

Please sign signature form for your consent.

Susan Haynes DMD
1795 AIRWAY AVENUE STE A, KINGMAN AZ, 86409
Phone (928) 692-1100, Fax (928) 692-1114

To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster and more efficient.

Here at Let's C U Smile we have implemented a similar policy. You will be asked for a credit/ debit card number at the time you check in and the information will be held securely until your insurance(s) have paid their portion and notified us of the amount of your share. At that time, Let's C U Smile will notify you by phone, the balance will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely yours,

Susan Haynes DMD

I authorize Let's C U Smile, to charge outstanding balances on my account to the following credit/debit card:

Visa Mastcard CareCredit Discover

Other:_____

Account Number_____Exp Date_____ SCode_____

Name on card (Please Print)_____

Signature_____ Date_____

Adjunctive Oral Cancer Screening Acceptance Form

Complete each time the examination is performed and place in the patient's file

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and look for it in all at risk patients.

One person dies every hour from oral cancer in the United States.

Late detection of oral cancer is the primary reason that mortality rates are so dismal. As with most other cancers, age is the primary risk factor for oral cancer. Though tobacco use is a major predisposing risk factor, **25% of oral cancer victims have no lifestyle risk factors.**

Oral Cancer Risk profile

Increased risk

- Patients age 40 and older (95% of all cases)
- 18-39 years of age combined with any of the following:
  - Tobacco use
  - Chronic alcohol consumption
  - Oral HPV infection

Highest risk

- Patients age 65 and older with lifestyle risk factors
- Patients with history of oral cancer

• 25% of oral cancers occur in people who don't smoke and have no other risk factors.

We find that using ViziLite Plus along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. ViziLite Plus is a painless exam that gives us a better chance to find any oral abnormalities you may have at an early stage.

Dental insurance might not cover the ViziLite Plus exam. However, this office is happy to verify your coverage for you and will also provide you with a medical insurance form for you to use to file this procedure with your medical insurance. The fee for this enhanced examination is $_____.

Yes. I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name: _____

Signature: _____ Date: _____

No. I would prefer not to have the ViziLite Plus exam at this time.

Print name: _____

Signature: _____ Date: _____

Let's C U Smile

Susan Haynes, DMD

HIPPA NOTICE OF PRIVACY PRACTICES

("Notice")

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 Dental Practice Covered By This Notice

This notice describes the privacy practices of Let's C U Smile. "We" and "Our" means the Dental Practice. "You" and "Your" means our patient.

How to Contact Us/ Our Privacy Official

If you have any questions or would like further information about this notice, you can either write to or call the Privacy Official for our Dental Practice:

Dental Practice Name:	Let's C U Smile
Privacy Official for Dental Practice:	Susan Haynes, DMD
Dental Practice Mailing Address:	1795 Airway Ave, Suite A Kingman, AZ 86409
Dental Practice Email Address:	
Dental Practice Phone Number:	928-692-1100

Information Covered By This Notice

This notice applies to health information about you that we create or receive and that identifies you. This notice tells you about the ways we may use and disclose your health information. It also describes your rights and certain obligations we have with respect to your health information. We are requires by law to:

- Maintain the privacy of your health information;
- Give you this notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our notice that is currently in effect

Our Use and Disclose of Your Health Information Without Your Written Authorization

Common Reasons for Our Use and Disclosure of Patient Health Information

Treatment. We will use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, voicemail, or email.

Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health related benefits and services that may be of interest to you.

Disclosure to Family Members and Friends. We may disclose health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

Less Common Reasons for Use and Disclosure of Patient Health Information.

The following uses and disclosures occur infrequently and may never apply to you.

Disclosures Requires by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the Health care system, certain government programs, and compliance with certain civil rights laws.

Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

Law Enforcement Purposes. We may disclose patient health information to a law enforcement official for law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

Coroners, Medical Examiners and Funeral Directors. We may disclose patient health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

Organ, Eye and Tissue Donation. We may use or disclose patient health information to organ procurement organizations or others to obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

Research Purposes. We may use or disclose patient health information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

Serious Threat to Health or Safety. We may use or disclose patient health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

Specialized Government Functions. We army disclose patient health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

Workers' Compensation. We may disclose patient health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

Your Written Authorization for Any Other Use or Disclosure of Your Health Information

We will make other uses and disclosures of health information not discussed in this notice only with your written authorization. You may revoke that authorization at any time in writing. Upon receipt of the written revocation, we will stop using or disclosing your health information for the reasons covered by the authorization going forward.

Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

Access. You may request to review or request a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of the denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that it mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

Amend. If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of denial and can file a statement of disagreement that will be included with our health information that you believe is incorrect or incomplete.

Restrict Use and Disclosure. You may request that we restrict uses of your health information to carry our treatment, payment, or health care operations or to your family member or friend involved in your care or the payment of your care. We may not (and are not required to) agree to your requested restrictions, with one exception. If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

Confidential Communications: Alternative Means, Alternative Locations. You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate for payment of services will be handled.

Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information for the six years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We will charge a reasonable fee to cover the cost of each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

Receive 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 paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

We Have the Right to Change Our Privacy Practices and This Notice.

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our

legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice (including any updates) is in the top right-hand corner of the Notice.

To Make Privacy Complaints

If you have any complaints about your privacy rights and how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

The privacy of your health information is important to us. We will not retaliate against you in any way if you choose to file a complaint.