PATIENT REGISTRATION

Patient's Name: _____ Date of Birth: _____ SSN: _____

Name of Spouse/Partner: _____ Date of Birth: _____ SSN: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____ E-Mail: _____

If patient is a minor: Parent's Name _____

Name of Policy Holder: _____ Policy Holder's DOB: _____ Policy Holder's SSN: _____

Insurance Company: _____

Group Number: _____ ID Number: _____

Address to Submit Claim: _____

_____

How did you hear about our office? _____

EMERGENCY INFO:
Name and Telephone number of a relative not living with you.

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.
Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and Discover. Outside financing is available upon request and approval.
Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.
Do you have insurance?

- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company by cash, check, MasterCard, Visa or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter your dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.
CONSENT:
The undersigned hereby authorizes the Doctors to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctors to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctors to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand the responsibility for payment for Dental Services provided in this office for myself or my dependents is mine due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

PATIENT Signature (Parent of Child) _____ Date: _____

DENTAL HISTORY

What is the most important thing to you about your dental visit today?

_____

Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding of clenching teeth
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath

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

- ☐ Complete Dentures
- ☐ Partial Dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

Please share the following dates:

- Your last cleaning ___/___
- Your last oral cancer screening ___/___
- Your last complete X-Rays ___/___

Do you smoke or use chewing tobacco? Y / N

For how long? _____

I would like information about the following:

- ☐ Make them whiter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

MEDICAL HISTORY

Please check any of the following that apply to you:

- ☐ A-fib
- ☐ Allergies (Seasonal)
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bisphosphates
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain/Discomfort
- ☐ CHF
- ☐ Cholesterol
- ☐ Daily Aspirin
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Lesions
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis A, B, C
- ☐ High Blood Pressure
- ☐ HIV Positive/AIDS
- ☐ Jaundice
- ☐ Jaw Joint Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervousness/Depression
- ☐ Nitro Glycerin
- ☐ Nursing
- ☐ Pacemaker
- ☐ Phen Fen (1 month+)
- ☐ Pregnant Currently
- ☐ Psychiatric Treatment
- ☐ Radiation (Head/Neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Diseases

Do you have any of the following drug allergies?

- ☐ Amoxicillin
- ☐ Aspirin
- ☐ Cephalexin
- ☐ Ciprofloxacin
- ☐ Cleocin/Clindamycin
- ☐ Codeine
- ☐ Doxycycline
- ☐ Erythromycin
- ☐ Latex Allergy
- ☐ Local Anesthetic
- ☐ Opioids
- ☐ Penicillin
- ☐ Percodan
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Valium
- ☐ Other

Are you under a physician's care? Circle: Y / N
For? _____

Are you taking any medications? Please list below.

_____

_____

Family Physician & Phone Number: _____

I acknowledge that I am responsible for informing the doctor about any changes in my health history prior to treatment. I understand that my health history information will be used as necessary for diagnosis or treatment by the doctors at The Dental Office of Dunedin. I understand that antibiotics may reduce the effectiveness of birth control pills.

Patient Signature: _____ **Dentist Signature:** _____ **Date:** _____

COMPLETE FOR SUBSEQUENT VISITS ONLY: I have read my answers to the health history questions listed above and there are no changes.

(1) _____ Patient Initials + Date
(2) _____ Patient Initials + Date
(3) _____ Patient Initials + Date
(4) _____ Patient Initials + Date

(1) _____ Doctors' Initial + Date
(2) _____ Doctors' Initial + Date
(3) _____ Doctors' Initial + Date
(4) _____ Doctors' Initial + Date

Patient Name: _____

DENTAL OFFICE OF DUNEDIN
PROGRESSIVE. COMPREHENSIVE. COMPASSIONATE

Please read this information before signing.

INFORMATION REGARDING BISPHOSPHONATES

Bisphosphonates are a class of drugs that are used to treat osteoporosis in women. Stronger forms of bisphosphonates are sometimes used in the treatment of certain cancers, as well as, for a disorder called Paget's disease.

A connection has been made between bisphosphonate type drugs and a serious bone disease called Osteonecrosis of the Jaw. The United States Food and Drug Association, along with the manufacturer of one of these drugs (Fosamax) issued a warning to health care professionals on this issue on September 24, 2004.

It is very important for you to let us know if you are now, or have ever taken in the past, **ANY** type of bisphosphonate class drug. If we treat you without knowing if you are now taking, or have taken in the past, any of these drugs, your health could be seriously affected. These drugs continue to affect the body for years after they are no longer being taken, so we **MUST** know if you have ever taken any of them. Some most common brand names and generic names have been listed below. Please know that the names listed below are the most common, but some others may be prescribed.

Fosamax (Alendronate)

Zometa (Zoledronic Acid)

Aredia (Pamidronate)

Actonel (Risedronate Sodium)

Boniva (Ibandronate)

Bonefos (Clodronate)

Skelid (Tiludronate Sodium)

Didronel (Etidronate Disodium)

Prolia/Xgeva (Denosumab)

Forteo (Teriparatide)

Reclast (Zoldronic Acid-Mannitol)

Are you now, or have you in the past, taken a bisphosphonate drug?

YES _____ NO _____ Last Taken date: _____

Patient Signature: _____ Date: _____

DENTAL OFFICE OF DUNEDIN
PROGRESSIVE. COMPREHENSIVE. COMPASSIONATE

Patient Name: _____

Chart # _____

Please read this information before you sign it.

Acknowledgement of Receipt of Notice of Privacy Practice

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgment.

You may refuse to sign this acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

Authorization to Release Information

I hereby authorize the Dental Office of Dunedin, Inc. to discuss my protected health information with the following person(s):

Name:_____Relationship _____

Name:_____Relationship: _____

-OR ☐ I decline. Please do not discuss my care with anyone other than allowed by HIPAA regulations.

Authorization to Leave a Detailed Message

I hereby authorize the Dental Office of Dunedin, Inc. to leave a detailed, personal message at the phone numbers/ emails I have provided. (Please circle the following):

Email

Voicemail on Home Phone

Voicemail or text on Cell Phone

Voicemail on Work Phone

With my signature below, I acknowledge and understand that this Authorization will be kept in my records and that the communication parameters listed above will remain in effect until revoked by me in writing. It is my responsibility to notify the Dental Office of Dunedin, Inc., in writing should I wish to change one or more of the telephone numbers and/or contacts listed above.

Signature_____Date: _____

If you refuse to sign this document, please initial and date below.

_____ _____

DENTAL OFFICE OF DUNEDIN
PROGRESSIVE. COMPREHENSIVE. COMPASSIONATE

Patient Name: _____

Chart # _____

Financial Policy

Please read this information before you sign it.

We, the staff of the Dental Office of Dunedin, Inc. thank you for choosing us as your dental provider. We consider it a privilege to serve your dental needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a harmonious provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies or responsibilities please feel free to contact us. We believe this level of communication and cooperation will allow us to continue to provide quality service to all our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa, Discover, American Express, Care Credit). A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect copayments, co-insurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability. They do so with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier. _____(Patient Initials)

Miscellaneous Forms, Additional Information and Authorizations

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports, or extracurricular activities there will be an administrative fee, not to exceed $35.00, for the additional information. _____(Patient Initials)

Missed Appointments

We require notice of cancellations 48 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are typically $40.00 but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients. _____(Patient Initials)

Medical Records Fees

By law we are required to keep a patient's original x-rays and record in this office. Original x-rays or records will NOT be released. The patient or a designated person may request copies of their x-rays or record, however, there is a fee for duplication. We also require notice to copy x-rays. There is no fee for us to send x-rays to a specialist that we refer you to. _____(Patient Initials)

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

I have read and understand the above financial policy. I agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Patient Signature: _____ Date: _____

DENTAL OFFICE OF DUNEDIN
PROGRESSIVE. COMPREHENSIVE. COMPASSIONATE

Patient Name: _____

Chart # _____

General Consent Form

Please read this information before you sign it.

Medical History Information

Please understand that it is important that you divulge any information about your medical history to your dentist. It is important that you inform us of any medicines that you are taking each time that you come to an appointment as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics, or other medications. Please be sure to provide us with a list of any drug allergies you have. _____(Patient Initials)

Restorations

I understand that care must be exercised in chewing on fillings until directed by doctor or staff to avoid breakage or soft tissue damage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that sensitivity may occur after a newly placed filling. _____(Patient Initials)

Changes in Treatment

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make any/all changes and additions as necessary after consultation. _____(Patient Initials)

Complications

Complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is transient but on infrequent occasion, may be permanent), reaction to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure. The risks of complications from medications used/prescribed with general dental treatment include, but are not limited to, drowsiness, lack of awareness and coordination, nausea, allergic reactions, etc. (which may be influenced using alcohol, tranquilizers, sedatives, or other drugs). [It is not advisable to operate any motor vehicle or hazardous device while experiencing side effects of the medications we may prescribe.] [Antibiotics are known to decrease the effectiveness of oral contraceptives, so it is advised that other contraceptive measures be taken during the administration of antibiotics.] _____(Patient Initials)

X-rays and Photos

Modern dental x-ray equipment is extremely low-dose radiation. Diagnostic x-rays provide the dentists with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Our office takes x-rays or panoramic x-rays to allow us to do a thorough exam for each patient. All patients 6 years and older will receive a full mouth series of intra-oral x-rays. Without these x-rays, we cannot do a complete exam of the entire mouth and jaw. We may also take photos of our patients as part of their permanent record. We will not release these photos to anyone without your permission. _____(Patient Initials)

Specific Problem Examinations

If a patient requests only a specific problem be addressed (i.e.: broken tooth, pain in one area, etc.) this is considered a problem focused evaluation. X-rays will be taken in this specific area only, and a complete comprehensive examination will not be done. The dentist cannot diagnose problems in other areas of the mouth. Please understand that this appointment will be for the treatment/diagnosis of an emergency/urgent need. Any future treatment of other areas will require additional x-rays and a complete exam. You will only be considered a patient of record unless this examination is completed. _____(Patient Initials)

DENTAL OFFICE OF DUNEDIN
PROGRESSIVE. COMPREHENSIVE. COMPASSIONATE

Patient Name: _____

Chart # _____

General Consent Form

Please read this information before you sign it.

Crowns, Bridges and Veneers

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge, or veneer (including shape, fit, size, placement, and color) will be done before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that sometimes when taking a final impression, trimming of the gum tissue (gingivectomy) is necessary. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. _____(Patient Initials)

Dentures—Complete or Partial

I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be “teeth in wax” try-in visit. I understand that most dentures require relining after initial placement. The cost for this procedure is not included in the initial denture fee. Failure to wear dentures every day will likely lead to tooth movement, resulting in a denture that no longer fits. _____(Patient Initials)

Specialty Referral and/or Second Opinion

General dentists perform much of all dental treatment today. However, we want all patients to be aware that specialty fields exist in dentistry, particularly in the fields of oral surgery, orthodontics, periodontics, pediatric dentistry, and endodontics. In some cases, we may have to refer certain procedures out to a specialist. We would be happy to offer you the names of specialists in order for you to have a second opinion and/or have actual treatment performed by a specialist. _____(Patient Initials)

I hereby authorize the dental staff of the Dental Office of Dunedin, Inc. to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is **only an estimate** and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfactions.

Patient Signature: _____ Date: _____

Print Patient Name: _____

DENTAL OFFICE OF
DUNEDIN
PROGRESSIVE. COMPREHENSIVE. COMPASSIONATE

1044 Belcher Road
Dunedin, Florida 34698
727-738-8845 Office * 727-738-1466 Fax
info@dunedindental.com
Nikki@dunedindental.com

Date: _____

To: _____

Email or fax #: _____

Name of Patient: _____

Date of Birth: _____

I hereby authorize and request _____ to disclose and give copies to Dental Office of Dunedin Inc, **any and all records and information concerning the undersigned** which you may have in your possession; including but not limited to the following: dental records, including operative records, diagnosis, dental history, findings and procedures, treatment and interviews, radiographs, diagnostic models and additional materials. **Please send x-rays in Dexis format if applicable, or jpeg in INDIVIDUAL IMAGES**.

In consideration of such disclosure on the part of above-named person or institutions, I hereby release them from any and all liability arising from such disclosure.

Please forward to:

The Dental Office of Dunedin Inc
1044 Belcher Road
Dunedin, FL 34698

Fax: 727-738-1466
or via e-mail: nikki@dunedindental.com or info@dunedindental.com

Signed,

_____

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 such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new 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 significant 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 health care 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 health care 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 Patients 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 indentifying 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 this is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common 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 reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible 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 authorize 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 practically 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 change you $0.25 for each page, $15.00 per hour of 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, health care operations and certain other activities, for the last 6 years, but not before April 14th, 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 satisfactory explanation how payments will be handled under the alternative means or location you requested.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you received this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS:

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services.

Fax: 727-738-1466
Address: 1044 Belcher Road, Dunedin, FL 34698

Telephone: 727-738-8845
E-Mail: info@dunedindental.com

Contact Officer: Region IV, Office for Civil Rights (Florida)
Telephone: 1-404-562-7886

Fax: 1-404-562-7881

Address: U.S Department of Health and Human Services, Atlanta, Georgia 30303