Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

How Did You Hear About Us?

□ **Phone Book**	□ **Street Sign**	□ **Statesman Journal**
□ **Insurance:**	□ **Postcard**	□ **Valpak**
□ **Internet Site:**	□ **Is there someone we can thank for referring you?**	□ **Other:**

Responsible Party Who is responsible for the account?	
Name:	
Relationship to patient:	
Birthdate:	
Driver's License#:	
SS# or Subscriber Identification # (SIN):	
Address:	
City:	
State:	
Zip:	
Employer:	
Occupation:	**Best way to verify appt.:**
Work Phone:	□ Work
Home Phone:	□ Home
Cell Phone:	□ Cell
E-mail:	□ E-mail

Financial Arrangements	Late Charges
For your convenience, we offer the following methods of payment. Please check the option which you prefer:	If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.
□ **Cash**	
□ **Debit Card**	
□ **Credit Card**	
□ **Care Credit**	
*Personal checks are not accepted. Payment is expected at the time of service.	**Signature**________________________________ **Date**__________________________________

Turn Page Over →

Primary Dental Insurance Information	Secondary Dental Insurance Information
Name of Insured:	Name of Insured:
Relationship to Patient:	Relationship to Patient:
Insured's Birthdate:	Insured's Birthdate:
SS#/SIN:	SS#/SIN:
Employer:	Employer:
Insurance Company:	Insurance Company:
Group #:	Group #:
Employee/Cert.#:	Employee/Cert.#:
Ins. Co. Address:	Ins. Co. Address:
Ins. Co. Phone:	Ins. Co. Phone:

Dental Insurance Agreement

We are happy to help you file your insurance claims to receive the dental benefits which your employer and you are paying premiums. Dental benefit plans can vary from company to company with different procedures covered or not covered. Insurance companies base the amounts that they will pay toward your dental treatment on restricted fee schedules related to premium payments and geographical location. Meaning your insurance plan will pay only what it allows for each service, regardless of what the actual fee is. Deductibles and co-payments are typically built in to most plans and their required payment is strictly regulated by state law. Your Employee Benefits Director can usually help you become familiar with your plan and any restrictions that may apply. Our office is happy to assist you in maximizing your benefits.

We agree to:
Complete your insurance claim forms and submit them to your carrier for you after treatment in our office.
Use current American Dental Association coding for correct reporting of procedures.
Accept direct payment from your carrier and keep track of balances.
If necessary, re-file your insurance a second time.
Your responsibilities as a patient:
To pay fees not covered by your plan at the time of treatment.
To provide our office with necessary information concerning your insurance coverage to allow correct filing of claims.
To understand that your plan is a contract between you and your employer and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.
To pay any account balance not paid by insurance.

We thank you for choosing our office and will do all we can to help you maximize your benefits for the year. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help. We will keep one copy in your chart and will give you a copy for your records upon request.

I hereby authorize payment directly to the dental providers from my dental insurance company. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to this office to provide information to my insurance company regarding my dental treatment. I also authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to other health practitioners.

Patient or Insured ______________________ Date ______________

Formulario para la Historia de Salud

ADA American Dental Association®
America's leading advocate for oral health

Email: Fecha de hoy:

Como lo requiere la ley, nuestra oficina se adhiere a las políticas y a los procedimientos escritos para proteger la privacidad de la información que creamos, que recibimos o que mantenemos sobre usted. Sus respuestas son para nuestros registros solamente y se mantendrán en forma confidencial de acuerdo a las leyes vigentes. Por favor, advierta que se le harán algunas preguntas sobre sus respuestas a este cuestionario y que pueden hacerle preguntas adicionales respecto a su salud. Esta información es vital y nos permitirá entregarle una atención apropiada. Esta oficina no usará estos datos para hacer discriminaciones.

Nombre: *Apellido* *Nombre* *2o Nombre*
Teléfono de Casa: *Incluya código del área* ( )
Teléfono de Oficina/Celular: *Incluya código del área* ( )

Dirreción: *Dirreción postal*
Ciudad: Estado: Código postal:

Ocupación: Altura: Peso: Fecha de nacimiento: Sexo: M F

SS# o ID del Paciente: Contacto en Emergencias: Parentesco: Teléfono: *Incluya código del área* ( ) Teléfono celular: *Incluya código del área* ( )

Si usted está llenando este formulario para otra persona, qué parentesco tiene con esa persona?

Su Nombre *Parentesco*

Tiene alguna de estas enfermedades o problemas: *(Marque NS si usted No Sabe la respuesta a esta pregunta)*

	Sí	No	NS
Tuberculosis activa	☐	☐	☐
Tos persistente de más de 3 semanas de duración	☐	☐	☐
Tos que produce sangre	☐	☐	☐
Ha estado en contacto con alguien que tiene tuberculosis	☐	☐	☐

Si su respuesta es Sí a cualquiera de estos 4 problemas, por favor deténgase y devuelva este formulario a la recepcionista.

Información Dental *En las preguntas siguientes haga el favor de marcar su respuesta con una (X) donde corresponda.*

	Sí	No	NS
Le sangran las encías cuando se cepilla o cuando usa seda dental?	☐	☐	☐
Le duelen los dientes con el frío, calor, con los dulces o al presionar?	☐	☐	☐
Le quedan alimentos o seda dental atrapados entre los dientes?	☐	☐	☐
Sufre de boca seca?	☐	☐	☐
Ha tenido algún tratamiento periodontal (de la encía)?	☐	☐	☐
Ha tenido tratamientos de ortodoncia (con aparatos)?	☐	☐	☐
Ha tenido algún problema asociado con un tratamiento dental anterior?	☐	☐	☐
Está fluorada el agua que llega a su casa?	☐	☐	☐
Bebe usted agua embotellada o filtrada?	☐	☐	☐

Si es así, con qué frecuencia? *Marque su respuesta con un círculo:*
A DIARIO / SEMANALMENTE / OCASIONALMENTE

	Sí	No	NS
Tiene dolor o molestias dentales en este momento?	☐	☐	☐
Sufre de dolor de oídos o del cuello?	☐	☐	☐
Tiene algún ruido, salto o molestia en la mandíbula?	☐	☐	☐
Tiene bruxismo o hace rechinar los dientes?	☐	☐	☐
Tiene lesiones o úlceras en su boca?	☐	☐	☐
Usa dentaduras (placas) completas o parciales?	☐	☐	☐
Participa en actividades enérgicas de recreación?	☐	☐	☐
Ha sufrido alguna lesión grave en la cabeza o en la boca?	☐	☐	☐

Fecha de su último examen dental:

Qué le hicieron en esa ocasión?

Fecha de su última radiografía dental:

Cuál es el motivo de su visita al dentista hoy?

Cómo se siente con su sonrisa?

Información Médica *Haga el favor de marcar su respuesta con una (X) para indicar si tiene o ha tenido alguna de las siguientes enfermedades o problemas.*

	Sí	No	NS
Se encuentra ahora bajo el cuidado de un médico?	☐	☐	☐

Médico: *Nombre*
Teléfono: *Incluya código del área* ( )

Dirección/Ciudad/Estado/Código:

	Sí	No	NS
Se encuentra usted sano/a?	☐	☐	☐
Ha habido algún cambio en su salud general durante el último año?	☐	☐	☐

Si es así, qué condición le están tratando?

Fecha de su último examen médico:

	Sí	No	NS
Ha tenido alguna enfermedad grave, operación o ha sido hospitalizado/a en los últimos 5 años?	☐	☐	☐

Si es así, cuál fue la enfermad o el problema?

	Sí	No	NS
Está tomando o ha tomado recientemente algún medicamento recetado o sin receta?	☐	☐	☐

Sí es así, por favor indique cuáles son, incluyendo vitaminas, preparados naturales o a base de hierbas y/o suplementos dietéticos:

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Form S501

Información Médica

Haga el favor de marcar su respuesta con una (X) para indicar si tiene o ha tenido alguna de las siguientes enfermedades o problemas.

(Marque NS si usted No Sabe la respuesta a esta pregunta) **Sí No NS**

Usa lentes de contacto? ☐ ☐ ☐

Articulaciones Artificiales. Ha tenido algún reemplazo ortopédico total de una articulación (cadera, rodilla, codo, dedo)? ☐ ☐ ☐

Fecha: ______________ Si es así, ha tenido alguna complicación? ___________________

Está tomando o tiene que empezar a tomar un agente antirresortivo (como Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) debido a osteoporosis o a enfermedad de Paget? ☐ ☐ ☐

Desde el año 2001, ha sido tratado/a o está actualmente en lista para comenzar tratamiento con un agente antirresortivo (como Aredia®, Zometa®, XGEVA) para dolor óseo, hipercalcemia o complicaciones esqueléticas derivadas de la enfermedad de Paget, mieloma múltiple o cáncer metastásico? ☐ ☐ ☐

Fecha del comienzo del Tratamiento: ____

Sí No NS

Usa sustancias reguladas (drogas)? ☐ ☐ ☐

Usa tabaco (fumado, aspirado/rapé, masticado, en bidis)? ☐ ☐ ☐
Si es así, le interesaría dejar de hacerlo?
Marque con un círculo: MUCHO / ALGO / NO ME INTERESA

Bebe bebidas alcohólicas? ☐ ☐ ☐

Si es así, cuánto alcohol bebió en las últimas 24 horas? ____________________________

Si es así, cuánto bebe por lo general en una semana? ______________________________

SÓLO MUJERES Está usted:

Embarazada? ☐ ☐ ☐
Número de semanas: ________________
Tomando píldoras anticonceptivas o de sustitución hormonal? ☐ ☐ ☐
Amamantando? ☐ ☐ ☐

Alergias. Es usted alérgico – o ha tenido alguna reacción – a:
En todas las respuestas **afirmativas**, especifique el tipo de reacción.

	Sí	No	NS
Anestésicos locales ______	☐	☐	☐
Aspirina ______	☐	☐	☐
Penicilina u otros antibióticos ______	☐	☐	☐
Barbituratos, sedativos o pastillas para dormir ______	☐	☐	☐
Sulfas ______	☐	☐	☐
Codeína u otros narcóticos ______	☐	☐	☐
Metales ______	☐	☐	☐
Látex (goma) ______	☐	☐	☐
Yodo ______	☐	☐	☐
Polen (fiebre del heno)/estacional ______	☐	☐	☐
Animales ______	☐	☐	☐
Alimentos ______	☐	☐	☐
Otros ______	☐	☐	☐

Por favor marque con una (X) su respuesta para indicar si usted ha tenido o no ha tenido algunas de estas enfermedades o problemas.

	Sí	No	NS
Válvula cardíaca artificial (prótesis)	☐	☐	☐
Previa endocarditis infecciosa	☐	☐	☐
Válvulas dañadas en corazón transplantado	☐	☐	☐
Enfermedad cardíaca congénita (ECC)			
ECC cianótica, sin reparar	☐	☐	☐
Reparada en los últimos 6 meses (completamente)	☐	☐	☐
ECC reparada con defectos residuales	☐	☐	☐

Aparte de las condiciones en la lista de arriba, ya no se recomienda realizar una profilaxis antibiótica para ninguna otra forma de ECC.

	Sí	No	NS
Enfermedad cardiovascular	☐	☐	☐
Angina	☐	☐	☐
Arterioesclerosis	☐	☐	☐
Insuficiencia cardíaca congestiva	☐	☐	☐
Daño en las válvulas cardíacas	☐	☐	☐
Infarto del miocardio	☐	☐	☐
Soplo en el corazón	☐	☐	☐
Presión arterial baja	☐	☐	☐
Presión arterial alta	☐	☐	☐
Otros defectos congénitos del corazón	☐	☐	☐
Prolapso de la válvula mitral	☐	☐	☐
Marcapasos	☐	☐	☐
Fiebre reumática	☐	☐	☐
Enfermedad cardíaca reumática	☐	☐	☐
Sangramiento anormal	☐	☐	☐
Anemia	☐	☐	☐
Transfusión sanguínea Si es así, fecha: ______	☐	☐	☐
Hemofilia	☐	☐	☐
SIDA o infección por VIH	☐	☐	☐
Artritis	☐	☐	☐
Enfermedad autoinmune	☐	☐	☐
Artritis reumatoidea	☐	☐	☐
Lupus eritematoso sistémico	☐	☐	☐
Asma	☐	☐	☐
Bronquitis	☐	☐	☐
Enfisema	☐	☐	☐
Sinusitis	☐	☐	☐
Tuberculosis	☐	☐	☐
Cáncer/Quimoterapia/ Radioterapia	☐	☐	☐
Dolores de pecho por esfuerzo	☐	☐	☐
Dolor crónico	☐	☐	☐
Diabetes Tipo I o II	☐	☐	☐
Trastornos de alimentación	☐	☐	☐
Malnutrición	☐	☐	☐
Enfermedad gastrointestinal	☐	☐	☐
Reflujo G.E./ardor persistente	☐	☐	☐
Úlceras	☐	☐	☐
Alteraciones de la tiroides	☐	☐	☐
Derrame cerebral	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, ictericia o enfermedad hepática	☐	☐	☐
Epilepsia	☐	☐	☐
Desmayos o ataques epilépticos	☐	☐	☐
Alteraciones neurológicas Si es así, especifique: ______	☐	☐	☐
Alteraciones del sueño	☐	☐	☐
Usted ronca?	☐	☐	☐
Alteraciones mentales Especifique: ______	☐	☐	☐
Infecciones recurrentes Tipo de infección: ______	☐	☐	☐
Alteraciones renales	☐	☐	☐
Sudor nocturno	☐	☐	☐
Osteoporosis	☐	☐	☐
Inflamación persistente de los ganglios del cuello	☐	☐	☐
Cefaleas graves/jaquecas	☐	☐	☐
Pérdida de peso severa o rápida	☐	☐	☐
Enfermedades venéreas	☐	☐	☐
Orina en forma excesiva	☐	☐	☐

Le ha recomendado algún médico o su dentista anterior que tome antibióticos antes de su tratamiento dental? ☐ ☐ ☐

Nombre del médico o del dentista que se lo recomendó: Teléfono: *Incluya código del área* (   )

Tiene alguna enfermedad, condición o problema que no figure más arriba y que cree que yo debería saber? ☐ ☐ ☐
Explique por favor:

NOTA: Se encarece tanto al doctor como al paciente que discutan detalladamente todos los aspectos relevantes de la salud del paciente antes del tratamiento.
Certifico que he leído y comprendido lo que aparece más arriba y que la información entregada en este formulario es exacta. Comprendo la importancia de que la historia de salud sea fidedigna y de que mi dentista y su personal puedan confiar en ella para realizar mi tratamiento. Reconozco que todas mis dudas sobre las preguntas de este formulario han sido respondidas satisfactoriamente. Yo no responsabilizaré a mi dentista ni a ningún miembro de su personal por las acciones que puedan tomar debido a los errores o a las omisiones que yo haya podido cometer al completar este formulario.

Firma del Paciente/Apoderado: Fecha:

Firma del proveedor.: Fecha:

A SER COMPLETADO POR EL ODONTÓLOGO/A

Comentarios:

COCHELL FAMILY DENTISTRY

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Our organization is committed to providing you with medical care that meets your needs. An important aspect of our service commitment to you is the protection and security of the protected health information that we obtain about you. We have always safeguarded your health information and our written privacy policy gives us an opportunity to share with you our policies that protect your health information.

We are required by law to provide you with this notice. It will describe to you what protected health information we collect about you and how that information might be used.

The Type Of Protected Health Information That We May Obtain About You:

Demographic Information: including your name, address, date of birth, phone number(s), name of your employer, your spouse or other family members, and emergency contact.

Insurance Information: including your insurance carrier, the name of the insured person, insurance identification numbers, and benefits and eligibility information.

Health Information: including your health history, past illnesses or injuries, family medical history, your social activities including use of tobacco, alcohol, or drugs, family life and living situation, your current and/or ongoing health problems, including medications, allergies, advised treatment and outcomes of that treatment.

Payment Information: including your insurance carrier, your record of charges, adjustments, and payments to our organization.

How We May Use and Disclose Protected Health Information About You:

Section 1:
We are not obligated to have your consent when using or disclosing protected health information for the following purposes:

A. **For Treatment:** We may use and disclose your health information to provide, coordinate or manage your health care and any related services. We may disclose information about you to doctors, dentists, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example:

◊ *If we schedule a test, therapy or surgery for you, we must provide information about you in order to complete the scheduling. This includes your name, demographic and insurance information and the reason for the test.*
◊ *Your doctor may share your medical information with another doctor who is also involved in your care so that both may have all the information to make the best treatment decisions for you.*
◊ *We may share information with a pharmacy so that they can fill or refill a prescription for you.*
◊ *We may share information about you with another provider who is on call in the absence of your provider.*

B. **For Payment:** We may use and disclose your information to obtain payment for services you receive. If you pay in full for service out of pocket you have the right to restrict your information being given to any health plan.

For example:

◊ *We may use or disclose your information to determine eligibility for insurance or benefits.*
◊ *We may use the name of your insurance carrier and your identification numbers in order to file a claim for you.*
◊ *We may disclose your information about your conditions or reasons for seeking care and the care that is provided to your insurance carrier so that they may process and pay your claim.*
◊ *We may disclose information about your conditions to your insurance carrier to seek approval as necessary for recommended tests and treatment.*
◊ *We may provide information about your services to a health care clearinghouse so that they may distribute a claim to your insurance carrier on our behalf.*

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◊ *If we refer you to another facility or provider we may provide them with your insurance information to expedite your registration and assure that they are participants in your insurance plan.*

C. **For Health Care Operations:** We may use or disclose protected health information about you in order to evaluate our care for you or to meet a business need of the organization. These activities include quality assessment activities, employee review activities, training students, compliance audits by your insurance carrier, and conducting or arranging for other business activities.

For example:

◊ *We may use information about you to evaluate the performance of our staff in caring for you.*
◊ *We may use your information to evaluate our efficiency.*
◊ *We may use your information to evaluate and respond to a patient complaint.*
◊ *We may share your health information with students or residents who are learning to care for patients.*

We may also use or disclose protected health information to our Business Associates in the performance of health care operations. A Business Associate is an entity or person engaged by this organization to perform a business activity on behalf of the organization. Our Business Associates are obligated by contract to protect health information they receive or generate about you.

For example:

◊ *We may provide information to our transcription service so that they can produce a written copy of your encounter in our office.*
◊ *We may provide information to our accountant in order to prepare our organization's financial reports.*
◊ *We may share information with qualified consultants in order for them to provide business management advice.*

D. **Other Contact Situations:**

◊ We may use your information to call and remind you of an appointment in our office.
◊ We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.
◊ We may tell you about health-related products or services that may be of interest to you.
◊ We may use your information for marketing, and fund raising you do have the right to opt out of the marketing and fund raising information.

E. **Special Situations:**

Emergencies: We may use or disclose protected health information in the case of a medical emergency.

Required by Law: We may use or disclose your protected health information if the disclosure is required by law.

Public Health: We may disclose protected health information about you for public health activities. These activities generally include the following:

◊ To prevent or control disease, injury or disability
◊ To report births or deaths
◊ To report child abuse or neglect
◊ To report reactions to medications or problems with products
◊ To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
◊ To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight: We may disclose protected health information to health oversight agencies that oversee our activities. These activities may include audits, investigations and inspections and are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits or Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. Subject to legal requirements, we may also disclose medical information about you in response to a subpoena.

Law Enforcement: We may disclose protected health information, so long as all applicable legal requirements are met, for law enforcement purposes.

Coroners, Medical Directors and Funeral Directors: We may disclose protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release information about patients to funeral directors as necessary to carry out their duties.

Workers Compensation: We may disclose medical information about you for programs that provide benefits for work-related injuries or illness.

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Military Activities, National Security and Intelligence Activities: If you are a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to disclose protected health information about you. We may also disclose information about foreign military personnel to the appropriate foreign military authority.

Organ and Tissue Donation: If you are an organ or tissue donor, we may disclose protected health information to organizations that handle organ or tissue procurement when necessary to facilitate organ or tissue donation or transplantation.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. The release would be necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use or disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Information that is not personally identifiable: We may use or disclose information about you in a way that does not personally identify you.

Section 2:
Protected Health Information Use and Disclosure That Requires an Opportunity for You to Agree or Object

Family and Friends: We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment of your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

Section 3:
Protected Health Information That Cannot Be Disclosed Without Your Specific Authorization:

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

You may revoke this authorization by notifying us in writing at any time.

Your Rights as a Patient:

◊ **You have the right to inspect and copy your protected health information.**
You may inspect and obtain a copy of your protected health information maintained in our office. We may charge you for the cost of copying, mailing or associated supplies.

Under federal law, however, you may not inspect or copy psychotherapy notes or information compiled in reasonable anticipation of a civil, criminal or administrative action or proceeding. Certain documents pertaining to laboratory services are also exempt under federal law.

You have the right to an electronic copy of your records however this office does not have electronic records. However we will copy your paper chart if requested in writing.

You have the right to request your records be sent via e-mail with the understanding that we will try and verify your email before sending. E-mail is not always secure and you are acknowledging this fact. This request must be done in writing.

Under certain circumstances, we may not grant your request. If we deny your request, then you may appeal our decision.

We require that requests to access your protected health information be made in writing. You can arrange to do this through our Privacy Officer.

◊ **You have the right to request a restriction of your protected health information.**
You may ask us not to disclose your protected health information for treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to friends and/or family members involved in your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency care.

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In order to request a restriction, you must do so in writing. The request must specifically state what information is restricted and to whom the restriction applies.

You may request a restriction form from our Privacy Officer.

◊ **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**
You may request that we communicate with you in a certain way or at a specific location. We will attempt to accommodate all reasonable requests.

Please contact our Privacy Officer to make this request in writing. Your request must specify where or how the communication is to be directed.

◊ **You have the right to request that we amend your protected health information.**
If you believe that protected health information we have about you is incorrect or incomplete, you may request an amendment to this information.

We may not grant your request if we determine that the protected health information that is the subject of your request:
◊ was not created by our organization
◊ is not a part of your medical or billing records
◊ is information that you are not permitted to inspect or copy
◊ is already a complete and accurate record

Amendment requests must be made in writing and must include a reason for requesting the amendment. If you wish to amend your record, you may contact our Privacy Officer for a form.

◊ **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**
You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than you, except for disclosures:
◊ to carry out treatment, payment and health care operations as described above
◊ to persons involved in your care or for other notification purposes as provided by law
◊ for national security or intelligence purposes as provided by law
◊ to correctional institutions or law enforcement officials as provided by law
◊ that occurred prior to April 14, 2003

You are allowed one free disclosure per each twelve-month period. If you wish additional disclosures within that twelve-month period, we may charge you the cost of providing the disclosure list.

Your request for a disclosure accounting must be made in writing. Please contact our Privacy Officer to obtain a form.

◊ **You have the right to file a complaint.**
If you believe that your privacy rights have been violated, you have a right to file a complaint in the form of a written letter with our office and with the Secretary of Health and Human Services without fear of retaliation.

A letter of complaint filed with this office should be sent to our Privacy Officer at the address listed below.

◊ **You have the right to request and receive a paper copy of this notice from our office.**

Revisions to Our Privacy Notice:

We are required to abide by the terms of this Privacy Notice. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. This notice is in effect as of September 23, 2013 Upon your request, we will provide you with a revised Privacy Notice. You may obtain this by calling our office and requesting that a revised copy be sent to you in the mail, or by asking for one at the time of your next appointment.

Questions/Contact:

If you have questions about this document, or have questions about privacy or patient rights, please contact our Privacy Officer.

Privacy Officer Name: Office Manager

Address: 2225 Mission St Suite 100 Salem, Or 97302

Phone Number: 503-585-8688

Cochell Family Dentistry

PRIVACY NOTICE ACKNOWLEDGEMENT

To Our Patients:

Federal law requires that we provide you with a copy of our Privacy Notice.

The Privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice.

If you have questions about the Privacy Notice, please feel free to direct these to our Privacy Officer at any time. The name and contact number of the Privacy Officer is listed on your copy of the Privacy Notice.

Patient Name:______________________________ Date of Birth:______________

Patient to complete this section

I have received a copy of the Privacy Notice for this organization on today's date.

Signed:______________________________________ Date: ___________________

If patient is unable to acknowledge receipt, staff member providing notice to complete this section

The Privacy Notice was provided to

Patient Name:__________________________ On ____________________

The patient was unable to acknowledge receipt of the Privacy Notice for the following reason:

____

____

____

Signed:_______________________________________

File this form in the patient's chart

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Authorization to Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers, physicians and specialists, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included; their names must be explicitly stated below.** You may opt out by checking the "Do not Release Information" box below.

Name of authorized person: ________________________________ Relationship: ________

____Appointments ____Financial ____Dental Treatment ____Insurance ____Other

Name of authorized person: ________________________________ Relationship: ________

____Appointments ____Financial ____Dental Treatment ____Insurance ____Other

Name of authorized person: ________________________________ Relationship: ________

____Appointments ____Financial ____Dental Treatment ____Insurance ____Other

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___DO NOT release information to anyone.

With my signature below, I acknowledge and understand that this information will be kept in my dental record and the above listed will remain in effect until revoked by me in writing. **It is my responsibility to notify my dental office should I wish to change one or more contacts listed above.**

Patient's Name: ________________________________ Date of Birth: ______________

____ Date: ________________

Signature of patient or patient's authorized representative

Thank You!