

**DMC DENTAL PRACTICE, INC
MAURICIO FONRODONA. D.D.S.
18981 Ventura Blvd. Suite 200.
Tarzana, CA 91356**

PATIENT MEDICAL HISTORY

Patient's Name: _____ Today's Date _____

Address: _____ Date of Last Visit: _____ Date of Med. History _____

City State Zip: _____ Email: _____

Home Phone: _____ Work Phone: _____ Birth Date: _____ SSN: _____ Marital Status: _____

Primary Dental Guarantor: _____ Home Phone: _____ Work Phone: _____

Secondary Dental Guarantor: _____ Home Phone: _____ Work Phone: _____

Physician Name: _____ Physician Phone: _____

Pharmacy: _____ Pharmacy Phone: _____

Sex: _____

If female please answer the following:
 Y N
 Are you taking Birth Control Pills?
 Are you pregnant? If yes, # of weeks
 Are you nursing?

Do you smoke or use tobacco?
 Y N
 Do you smoke or use tobacco?
 For office use only: BP Heart Rate

Height: _____

Weight: _____

Y N <input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> <input type="checkbox"/> Allergies <input type="checkbox"/> <input type="checkbox"/> Anemia <input type="checkbox"/> <input type="checkbox"/> Arthritis <input type="checkbox"/> <input type="checkbox"/> Artificial Bones <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> <input type="checkbox"/> Cancer- Chemotherapy <input type="checkbox"/> <input type="checkbox"/> Colitis <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect <input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> <input type="checkbox"/> Drug Abuse	Y N <input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> <input type="checkbox"/> Hay Fever <input type="checkbox"/> <input type="checkbox"/> Heart Attack <input type="checkbox"/> <input type="checkbox"/> Heart Surgery <input type="checkbox"/> <input type="checkbox"/> Hemophilia <input type="checkbox"/> <input type="checkbox"/> Hepatitis A <input type="checkbox"/> <input type="checkbox"/> Hepatitis B <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> HIV + AIDS <input type="checkbox"/> <input type="checkbox"/> Kidney Problems <input type="checkbox"/> <input type="checkbox"/> Liver Disease <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> <input type="checkbox"/> Pace Maker <input type="checkbox"/> <input type="checkbox"/> Pneumocystitis <input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems	Y N <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> <input type="checkbox"/> Seizures <input type="checkbox"/> <input type="checkbox"/> Shingles <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> <input type="checkbox"/> Sinus Problems <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/> Ulcers <input type="checkbox"/> <input type="checkbox"/> Venereal Disease <input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice Y/N <u>Allergies</u> Y/N <input type="checkbox"/> <input type="checkbox"/> Aspirin <input type="checkbox"/> <input type="checkbox"/> Dental Anesthetics <input type="checkbox"/> <input type="checkbox"/> Codeine <input type="checkbox"/> <input type="checkbox"/> Erythromycin <input type="checkbox"/> <input type="checkbox"/> Jewelry <input type="checkbox"/> <input type="checkbox"/> Latex
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Medications:

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Y N

Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below...

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Notes:

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Signature: _____
(If under 18, Parent or Guardian Signature Required)

Date: _____

**DMC DENTAL PRACTICE, INC
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Assignment of Insurance Benefits

I hereby authorize Mauricio Fonrodona , D.D.S. and / or DMC Dental Practice, Inc. to furnish information to insurance carriers concerning treatment and hereby assign to the doctors all payment for dental services rendered. This assignment will remain in effect until revoked by me in writing; a photocopy of this assignment is as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said Insurance / Dental Plan. I hereby authorize said assignee to release all information necessary to secure payment.

Signature

Date

Witness

Consent for Services

PLEASE READ AND SIGN BELOW

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients 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 financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable 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 breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian/responsible party

Date: _____ Relationship to Patient:

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Cancellation Policy

**** IF YOU ARE UNABLE TO KEEP AN APPOINTMENT, OUR OFFICE REQUIRES A 48 HOUR NOTICE. OTHERWISE A CHARGE WILL BE MADE FOR THE TIME RESERVED, IF WE ARE UNABLE TO FILL YOUR APPOINTED TIME.**

THANK YOU FOR YOUR COOPERATION IN HELPING TO KEEP OUR COSTS DOWN.

THANK YOU FROM THE DMC DENTAL PRACTICE TEAM!

Signature

Date

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Photography Release

I _____, hereby authorize Dr. Mauricio Fonrodona / DMC Dental Practice Inc, to take photographs, slides, and/or videos of my face, jaws, and teeth.

I understand that the photographs, slides and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including but not limited to website publications, newspapers, magazines, phone books, television) and professional publications (dental magazines and journals)

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs

Signature

Date

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PATIENT RELEASE FORM

1) CHANGES IN TREATMENT PLAN. I understand that as treatment progresses it may be necessary to change or add procedures due to conditions found during the process of treatment that were not readily evident at the exam and diagnosis phase of treatment and of which could require care by a specialist, the cost of which is my responsibility. I give my consent to these changes or additions. I understand that even minor treatment can result in sensitivity and even a routine procedure can necessitate root canal therapy. Initial _____

2) MEDICATIONS & ANESTHETICS. I understand that antibiotics, analgesics, anesthetics, medications and other dental supplies/products may be part of the treatment and can cause allergic reactions (redness, swelling, pain, itching, vomiting and/or anaphylactic shock) and can change the effectiveness, duration and interact with other medications taken. The injection of the anesthetic can cause temporary or indefinite changes in feeling (parasthesia) and motor control. Initial _____

3. REMOVAL OF TEETH (EXTRACTION). Alternatives to the removal of teeth have been explained to me as applicable (root canal therapy, crowns, periodontal surgery - etc) and I authorize the removal of Treatment Planned teeth and any others necessary (see paragraph #1). I understand the risks include pain, swelling, discomfort, the spread of infection, dry socket, parasthesia, (a change in feeling in my teeth, lips, tongue and surrounding areas that can be permanent in nature) and/or changes in motor control .I understand that removing teeth does not always remove all of the infection and infection caused changes. These and other complications that may occur during or following treatment may require further treatment by a specialist or even hospitalization, the cost of which is my responsibility. Initial _____

4) ROOT CANAL (ENDODONTIC TREATMENT). I understand that a root canal is an attempt to save a tooth and that complications (calcified canals, inaccessible canals, perforation & loss of the canal during treatment, instrument separation in the canal and/or fracture of the tooth crown, body or root) can occur. Other complications can include a reaction to a medication used, pain, swelling, continued infection and sensitivity to pressure even after treatment is completed. These and other complications that may occur during or following treatment may require further treatment (including retreatment, surgery on the root and/or extraction) by a specialist, the cost of which is my responsibility. Initial _____

5) FILLINGS. I understand that as treatment progresses, as in any restorative procedure, the cavity (caries) may be greater than expected. Initial _____

6) INLAYS, VENEERS, CAPS (CROWNS) AND BRIDGES. I understand that it is not possible to exactly match the color of natural teeth. I realize that the time to request changes (in color, shape, fit and size) is prior to cementation. I realize that permanent crowns are fabricated from materials that can be susceptible to fracture. I understand that the temporary placed interim to the placement of the permanent is fragile in nature and care must be taken not to break or dislodge it. The temporary is constructed to last only two to three weeks; postponing the placement of the permanent can allow tooth movement, necessitating a remake at an additional charge. Initial _____

7) DENTURES-COMplete OR PARTIAL. I understand problems in wearing dentures can include looseness, sore spots, decreased ability to speak/eat and breakage. Immediate dentures (dentures placed at the time of the extractions) have more discomfort and require additional adjustments. I realize that the time to request changes (in color, shape, fit, and size) is at the "teeth in wax" visit. Relines (at an additional fee) will be required as a denture loosens with tissue shrinkage. Initial _____

8) GUM (PERIODONTAL) TREATMENT. I understand that I have a serious and progressive disease that can lead to acute infection, pain and tooth loss. Treatment can include cleanings (scaling), deep cleanings (root planning), periodontal surgery (by referral to a specialist) and teeth considered hopeless or teeth that do not respond favorably to treatment will require extraction . I understand that post-therapy, my teeth may be sensitive to cold and sweets. I understand that postponement of care and other factors including the quality of home care can affect my ability to retain my natural dentition. Initial _____

9) IMPLANTS. I understand that implants have two main parts: an abutment (root form) and a restoration (suprastructure) portion. Poor healing or infection at the surgical site can lead to acute infection, pain and loss of the abutment and/or adjacent teeth. The restorative portion also may come lose or fracture requiring replacing screws or collars, recementation and/or complete loss of the suprastructure. Replacement of the abutment or suprastructure are additional procedures, the cost of which is my responsibility. I understand that smoking greatly increases the risk of abutment failure Initial _____

10) Temporomandibular Joint Dysfunction (TMD) I understand that symptoms of popping, clicking, locking, and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment where in the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually in nature and well tolerated by most patients, I understand that should the need arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility Initial _____

I understand that dentistry is as much an art as a science and because of this it is impossible to predict the outcome of treatment. I authorize my treating dentist(s) to proceed through the use of medications, materials and therapy as deemed appropriate as treatment progresses. I have no unanswered questions about treatment benefits/risks, or alternative treatment(s) and their benefits/risks
I have read, understand and agree to the above.

Patient _____ Date: _____

Witness _____ Date: _____

Doctor _____ Date: _____

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**Patient Acknowledgment of Receipt of Dental Materials Fact Sheet and Notice of
Privacy Practices**

As of January 1, 2002 the Dental Board of California now requires that we distribute to our patients a copy of the Dental Materials Fact Sheet. In addition, the Health Insurance Portability and Accountability Act (HIPAA) requires effective April 14, 2003 that patients be given a copy of our Notice of Privacy Practice.

If you would, please print and sign your name below.

I, _____, acknowledge I have received from this office

- A copy of the Dental Material Fact Sheet
- Notice of Privacy Practices

Patient Signature or Personal Representative

Date

If signed by a personal representative of the patient, describe the representative's authority to act for the patient _____

For Office Use

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgment.
- Other (Please specify)

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Comparisons of Indirect Restorative Dental Materials

TYPES OF INDIRECT RESTORATIVE DENTAL MATERIALS				
COMPARATIVE FACTORS	PORCELAIN (CERAMIC)	PORCELAIN (FUSED-TO- METAL)	GOLD ALLOYS (NOBILE)	NICKEL OR COBALT T- CHROME (BASE-METAL) ALLOYS
GENERAL DESCRIPTION	Glass-like material formed into fillings and crowns using models of the teeth.	Glass-like material that is "enamed" onto metal shells. Used for crowns and fixed bridges.	Mixtures of gold, copper and other metals used mainly for crowns and fixed bridges.	Mixtures of nickel, chromium.
PRINCIPLE USES	Inlays, veneers, crowns and fixed-bridges.	Crowns and fixed-bridges.	Cast crowns and fixed bridges; some partial denture frameworks.	Crowns and fixed bridges; most partial denture frameworks.
RESISTANCE TO FURTHER DECAY	Good, if the restoration fits well.	Good, if the restoration fits well.	Good, if the restoration fits well.	Good, if the restoration fits well.
ESTIMATED DURABILITY (PERMANENT TEETH)	Moderate; Brittle material that may fracture under high biting forces. Not recommended for posterior (molar) teeth.	Very good. Less susceptible to fracture due to the metal substructure.	Excellent. Does not fracture under stress; does not corrode in the mouth.	Excellent. Does not fracture under stress; does not corrode in the mouth.
RELATIVE AMOUNT OF TOOTH PRESEVED	Good-Moderate. Little removal of natural tooth is necessary for veneers; more for crowns since strength is related to its bulk.	Moderate-High. More tooth must be removed to permit the metal to accompany the porcelain.	Good. A strong material that requires removal of a thin outside layer of the tooth.	Good. A strong material that requires removal of a thin outside layer of the tooth.
RESISTANCE TO SURFACE WEAR	Resistance to surface wear; but abrasive to opposing teeth.	Resistant to surface wear; permits the metal to accompany the porcelain.	Similar hardness to natural enamel; does not abrade opposing teeth.	Harder than natural enamel but minimally abrasive to opposing natural teeth. Does not fracture in bulk.
RESISTANCE TO FRACTURE	Poor resistance to fracture.	Porcelain may fracture.	Does not fracture in bulk.	Does not fracture in bulk.
RESISTANCE TO LEAKAGE	Very good. Can be fabricated for very accurate fit of the margins of the crowns.	Good- Very good depending upon design of the margins of the bridges.	Very good- Excellent. Can be formed with great precision and can be tightly adapted to the tooth.	Good-Very good- Stiffer than gold; less adaptable, but can be formed with great precision.
RESISTANCE TO OCCLUSAL STRESS	Moderately; brittle material susceptible to fracture under biting forces.	Very good. Metal substructure gives high resistance to fracture.	Excellent.	Excellent.
TOXICITY	Excellent. No known adverse effects.	Very good. Metal substructure gives high resistance to fracture.	Excellent; Rare allergy to some alloys.	Good; Nickel allergies are common among women, although rarely manifested in dental restoration.
ALLERGIC OR ADVERSE REACTIONS	None.	Rare. Occasional allergy to metal substructures.	Rare; occasional allergic reactions seen in susceptible individuals.	Infrequent; replacement is usually due to recurrent decay around margins.
SUSCEPTIBILITY TO POST-OPERATIVE SENSITIVITY	Not material dependent; does not conduct heat and cold well.	Not material dependent; dies not conduct heat and cold well.	Infrequent; replacement is usually due to recurrent decay around margins.	Infrequent; replacement is usually due to recurrent decay around margins.
ESTHETICS (APPEARANCE)	Excellent.	Good to Excellent.	Poor-yellow metal	Poor-dark silver metal
FREQUENCY OF REPAIR OR REPLACEMENT	Varies; depends upon biting forces; fractures of molar teeth more likely the anterior teeth; porcelain fracture may often be repaired with composite resin.	Infrequent; porcelain fracture can often be repaired with composite resin.	Infrequent; replacement is usually due to recurrent decay around margins.	Infrequent; replacement is usually due to recurrent decay around margins.
RELATIVE COSTS OF PATIENT	High; requires at least two office visits and laboratory services.	High; requires at least two office visits and laboratory services.	High; requires at least two office visits and laboratory services.	High; requires at least two office visits and laboratory services.
NUMBER OF VISITS REQUIRED	Two-minimum; matching esthetics of teeth may require more visits.	Two-minimum; matching esthetics of teeth may require more visits.	Two minimum.	Two minimum.

NOTICE OF PRIVACY PRACTICES

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TARZANA, CA 91356

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAYBE USED IF AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on _____ and remains in effect until we

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We created a record of the care and services you receive at our organization. We need this record to provide you with quality care and not to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law requires us to;

1. Keep your medical information private.
2. Give you this notice describing our legal duties,
3. Follow the terms of the current notice.

We have the right to:

1. Change our privacy practices and the term of this notice at any time, provide that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your

NOTICE OF PRIVACY PRACTICES

specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purpose.

Facility directory: Unless you notify us that you object, the following medical information about you will be placed in facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contract us and ask information about you by name.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

NOTICE OF PRIVACY PRACTICES

Research in Limited Circumstances: We may use medical information for research purpose in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: to help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to court administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purpose of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: we may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: we may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

NOTICE OF PRIVACY PRACTICES

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. If you request copies, we will charge you \$- for each page, and postage if you want the copies mailed to you. contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

NOTICE OF PRIVACY PRACTICES

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may have also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.