



Welcome! How Did You Hear About Us?

Your Name _____ Date _____

Please Take a Moment and Check All That Apply:

_____ Signage

_____ Insurance Company

_____ Mailer/ Flyer

_____ Drive By

Internet Search Engine:

_____ Google

_____ Bing

_____ Yahoo

_____ Apollonia Dental Center Website

_____ Patient (So that we can thank them, please share your friend / patient's name)

_____ Business (Name of Business) _____

_____ Other (Please specify) _____

Health History Form



Email: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

| | | |
|---|---|---|
| Name: <i>Last</i> <i>First</i> <i>Middle</i> | Home Phone: <i>Include area code</i> () | Business/Cell Phone: <i>Include area code</i> () |
| Address: <i>Mailing address</i> | City: | State: Zip: |
| Occupation: | Height: | Weight: Date of Birth: Sex: M F |
| SS# or Patient ID: | Emergency Contact: | Relationship: Home Phone: <i>Include area code</i> () Cell Phone: <i>Include area code</i> () |
| If you are completing this form for another person, what is your relationship to that person? | | |
| <i>Your Name</i> | <i>Relationship</i> | |
| Do you have any of the following diseases or problems: | | <i>(Check DK if you Don't Know the answer to the the question)</i> |
| Active Tuberculosis..... | | Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Persistent cough greater than a 3 week duration..... | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Cough that produces blood..... | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Been exposed to anyone with tuberculosis..... | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| If you answer yes to any of the 4 items above, please stop and return this form to the receptionist. | | |

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

| Yes No DK | Yes No DK |
|--|---|
| Do your gums bleed when you brush or floss?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you have earaches or neck pains?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Are your teeth sensitive to cold, hot, sweets or pressure?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you have any clicking, popping or discomfort in the jaw?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Is your mouth dry?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you brux or grind your teeth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Have you had any periodontal (gum) treatments?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you have sores or ulcers in your mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Have you ever had orthodontic (braces) treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you wear dentures or partials?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Have you had any problems associated with previous dental treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you participate in active recreational activities?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Is your home water supply fluoridated?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Have you ever had a serious injury to your head or mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Do you drink bottled or filtered water?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Date of your last dental exam: |
| If yes, how often? <i>Circle one:</i> DAILY / WEEKLY / OCCASIONALLY | What was done at that time? |
| Are you currently experiencing dental pain or discomfort?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Date of last dental x-rays: |
| What is the reason for your dental visit today? | |
| How do you feel about your smile? | |

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

| Yes No DK | Yes No DK |
|--|---|
| Are you now under the care of a physician?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Have you had a serious illness, operation or been hospitalized in the past 5 years?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Physician Name: _____ Phone: <i>Include area code</i> () | If yes, what was the illness or problem? |
| Address/City/State/Zip: | Are you taking or have you recently taken any prescription or over the counter medicine(s)?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Are you in good health?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: |
| Has there been any change in your general health within the past year?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | _____ |
| If yes, what condition is being treated? | _____ |
| Date of last physical exam: | _____ |

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

| | |
|---|--|
| <p><i>(Check DK if you Don't Know the answer to the question)</i></p> <p>Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date Treatment began: _____</p> | <p style="text-align: right;">Yes No DK</p> <p>Do you use controlled substances (drugs)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p> <p>WOMEN ONLY Are you:</p> <p>Pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormonal replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> |
|---|--|

| | |
|--|---|
| <p>Allergies. Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.</p> <p>Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> | <p style="text-align: right;">Yes No DK</p> <p>Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay fever/seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> |
|--|---|

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

| | | |
|--|---|---|
| <p style="text-align: right;">Yes No DK</p> <p>Artificial (prosthetic) heart valve <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Previous infective endocarditis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged valves in transplanted heart <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congenital heart disease (CHD)</p> <p style="padding-left: 20px;">Unrepaired, cyanotic CHD <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired (completely) in last 6 months <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired CHD with residual defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> | <p style="text-align: right;">Yes No DK</p> <p>Autoimmune disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatoid arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Systemic lupus erythematosus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinus trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest pain upon exertion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chronic pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes Type I or II <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Eating disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Malnutrition <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Gastrointestinal disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>G.E. Reflux/persistent heartburn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> | <p style="text-align: right;">Yes No DK</p> <p>Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis, jaundice or liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, specify: _____</p> <p>Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you snore? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Mental health disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Specify: _____</p> <p>Recurrent Infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Type of infection: _____</p> <p>Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent swollen glands in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe headaches/migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sexually transmitted disease .. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Excessive urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> |
|--|---|---|

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

| | |
|---|---|
| <p style="text-align: right;">Yes No DK</p> <p>Cardiovascular disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arteriosclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congestive heart failure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart murmur <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other congenital heart defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> | <p style="text-align: right;">Yes No DK</p> <p>Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic heart disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood transfusion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, date: _____</p> <p>Hemophilia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>AIDS or HIV infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> |
|---|---|

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: _____ Phone: *Include area code* ()

Do you have any disease, condition, or problem not listed above that you think I should know about?

Please explain: _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____



INSURANCE INFORMATION

PRIMIARY COVERAGE

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ SSN# _____

Employer: _____ Work #: _____

Insurance Company: _____ Group #: _____

Union or Local: _____

SECONDARY COVERAGE

Do you have additional insurance coverage? Yes: No:

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ SSN# _____

Employer: _____ Work #: _____

Insurance Company: _____ Group #: _____

Union or Local: _____

I hereby authorized payment directly to Dr. Marvizi and Apollonia Dental. Dr. Marvizi and Apollonia Dental are authorized to release any information to insurance company(s), claim administrator(s) and consulting health care professionals.

By reading and signing this form, it is understood that ENGLISH is the language that I understand and use to communicate; otherwise I will have it translated for me by a third party before I sign.

Signature: _____ Date: _____



Apollonia Dental
Financial Policy

Payment is expected as services are rendered. We accept cash, checks, Visa, MasterCard, Discover, and American Express. We also provide a 90-day to 12-months interest free credit through G.E Capital. Financing upon request and subject to qualification.

For those patients covered by insurance, we are happy to extend the courtesy of billing your insurance company. However in order to provide this service to you, we must have complete insurance information. It is your responsibility to fill out the necessary forms that give us all the insurance information required.

For more extensive treatments if a pre-determination of insurance benefits is processed, you are then responsible for the co-payments at the time of service. If we have not received payment from your insurance company within 45 days of billing them, the balance becomes your responsibility. We wish our patients to know that all professional services rendered are charged directly to the patient and the patients are personally responsible for payment of fees, we will assist you in filling all insurance forms. Payment is due when services are rendered unless other arrangements have been made. If you must change a scheduled appointment, please inform us with a 48 hour notice, if we do not receive your notice we may regrettably, charge your account.

For all accounts beyond 45 days with amounts due, there will be a \$10.00 billing fee or a finance charge of 1.5% per month whichever is greater. We assign all accounts over 120 days to a collection service for processing.

Sincerely,

Apollonia Dental Long Beach
Joseph Marvizi, D.D.S.

I understand that I will be charged \$85.00 per appointment scheduled if I fail to keep an appointment or I do not notify the office of my change in schedule 48 hours before a scheduled appointment.

Should this account become past due, I agree to pay any reasonable additional fees, including any and all collection agency charges, legal fees and/or court costs, necessary to collect this account.

I agree to this financial policy and I have read and understood this document.

Patients signature

Date



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.

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect April 14, 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 anytime, provided such applicable law permits the changes. 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.

DISCLOSING HEALTH INFORMATION

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

To Your Family and Friends: We may disclose your health information to a family member friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of you incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general conditions.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluation practitioner and provider performance, conduction training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 anytime. Your revocation will not affect any uses 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.

- We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)
- We may use or disclose your health information to a public or private entity authorized by law or its charter to assist in disaster relief efforts.
- We may use or disclose your medical information as authorization by law for the following purposes deemed to be in the public interest of benefit:
 - As required by law;
 - For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employer regarding work- relating illness or injury;
 - To report adult abuse, neglect, or domestic violence;
 - To health oversight agencies;
 - In Response to court and administrative orders and other lawful processes;
 - To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or location a suspect or other person;
 - To coroners, medical examiners, and funeral directors;
 - To an organ procurement organizations;
 - To avert a serious threat to health or safety;
 - In connection with certain research activities;
 - To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
 - To correctional institutions regarding inmates; and
 - As authorized by state workers compensation laws.

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 practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee for providing your health information in that format. If you prefer we may-but are not required to- prepare a summary or an explanation of your health information for a fee.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in 12-month period, we may charge you a reasonable, cost-based fee responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Alternative Communications: 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. You must specify in your request that alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or locations you request.

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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

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

Patient or Responsible Party

Date