EASTERN DENTAL®

Building Smiles, Enhancing Lives

PATIENT REGISTRATION

DATE: ________________

PATIENT NAME LAST	FIRST ☐ MALE ☐ FEMALE	DATE OF BIRTH
		PATIENT SSN/ALT ID
ADDRESS	CITY	STATE ZIP
HOME PHONE ( )	WORK PHONE ( )	
CELL PHONE ( )	E-MAIL ADDRESS	

Best method of reaching you ____________________

If patient is a dependent, complete the following:

☐ Yes ☐ No Is patient covered by dental insurance?

☐ Yes ☐ No Is patient a dependent according to IRS standards? ☐ Yes ☐ No Is the patient disabled?

☐ Yes ☐ No Does patient attend college FT? Name and location of college ____________________

(Pick method of payment)

Payment: ☐ Cash ☐ Check ☐ Credit ☐ Debit

Driver's License #____________________

Referred by:

☐ Friend ☐ Union ☐ Newspaper ☐ Flyer ☐ Insurance Co. ☐ Website ☐ Other ______________

PERSON TO CONTACT IN CASE OF EMERGENCY	PHONE

INSURANCE INFORMATION (must be completed in full)

Please note that if you have any other dental insurance plans you must use both plans to coordinate benefits. The information provided will determine which carrier is the primary and which is secondary.

	PRIMARY	SECONDARY
Name of Insured		
Address		
Phone Number	( )	( )
Date of Birth		
Social Security Number/Alt Id		
Employer Name		
Employer Phone	( )	( )
Dental Insurance (Family, Individual)		
Group Number/I.D. Number		
Medical Insurance Carrier		
Union Name/Local Number		
Are you Hourly or Salary?		

To the best of my knowledge, the information provided is accurate. In the event that there are any changes in my current insurance plans, I will provide that information to Eastern Dental®. I understand that failure to provide such information may cause delays in processing or payment of my claims and I agree to pay if they are not paid timely as a result of such failure.

Signature: ______________________________ Date: ________________________

NOTIFICATION OF RESPONSIBILITY & SIGNATURE AUTHORIZATIONS

I agree to make payments as services are rendered. I understand that if for any reason my dental insurance does not make expected payment or if my insurance is terminated, I will be responsible for the TOTAL FEE.

I hereby authorize Eastern Dental® to execute in my name all payment application forms for treatment. The determination of treatment rendered by Eastern Dental® shall be conclusive.

Signed ______________________________________ Date ________________

Health History Form

Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that you 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 will allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle | Home Phone: *Include area code* ( ) | Business/Cell Phone: *Include area code* ( )

Address: Mailing Address | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of Birth: | Sex M F

SS# | Emergency Contact: | Relationship: | Home Phone: *Include area code* ( ) | Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name | Relationship

Do you have any of the following diseases or problems: ***(Check DK if you Don't Know the answer to the question)***

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

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
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply floridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY/WEEKLY/OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you clench or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

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
Are you now under the care of a physician?	☐	☐	☐

Physician Name: | Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and /or diet supplements:

Medical Information

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

(Check DK if you Don't Know the answer to the question)

Question	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date:_____ If yes, have you had any complications?_____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001,were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began:			
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week?_____			

WOMEN ONLY Are you:

Question	Yes	No	DK
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies- Are you allergic to or have you had a reaction to :
To all **yes** responses, specify type of reaction.

Allergy	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

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

Condition	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

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

Condition	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic Lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Question	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: | Phone

Question	Yes	No	DK
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 healthy 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

FOR COMPLETION BY DENTIST

Comments:_____

Financial Policy

Thank you for choosing our office as your dental healthcare provider. The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment. Please ask if you have any questions about our fees, policies, or your responsibility.

1. **Clear, Written Estimate on Cost of Treatment:** You will be provided with a comprehensive treatment plan with a detailed estimate of the cost of your treatment, including estimated insurance benefits and patient responsibility.

2. **Payment Policy:** Full payment of estimated patient responsibility is due at time of service. We accept cash, checks, American Express®, VISA®, MasterCard®, Discover® and CareCredit®.
   Adult patients are responsible for full payment of estimated patient responsibility at time of service.
   Minors accompanied by an adult: The adult accompanying a minor, his/her parents or guardians, are responsible for full payment of estimated patient responsibility at time of service.
   Unaccompanied minors: The parents or guardians are responsible for full payment of estimated patient responsibility at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to American Express®, VISA®, MasterCard® or Discover®.

3. **Insurance**:
   We process insurance claims as a courtesy to our patients. The estimated patient responsibility for dental service(s) is due at the time of service. This amount may be subject to adjustment once the insurance claim(s) is processed by your insurance company. While we will try to provide the best estimate of insurance benefits and patient responsibility, your insurance plan and benefits ultimately determine the amount paid. It is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility.

   Please contact your insurance company for a detail of your benefits. You are responsible for monitoring your benefits and may not rely upon any information provided by our staff regarding your remaining benefit in any annual benefit period.

   To the extent that the claims we submit to insurance companies may indicate that you have assigned those benefits to our office, this document represents an assignment of benefits and claims related in any way to the dental services you receive or are entitled to. If you receive direct reimbursement from your insurance company instead of receipt by your provider, please note that you then become responsible for the total account balance and payment would be expected immediately. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. You, as a patient, are always responsible for any charges that are not covered by your insurance.

4. **Third Party Financing:** We accept payment from non-affiliated, third party finance companies. Credit decisions are the responsibility of these third-party finance companies. You may choose to pay all or a portion of your treatment using approved third-party financing products.

5. **Delinquent Payments:** We may charge finance fees at 1.5% of outstanding patient balance after the balance has been outstanding for 30 days. In addition, all payments returned due to insufficient funds will be subject to a fee of $25.

6. **Missed Appointments**: In order to provide the best services to our patients, we require at least a 24-hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. Multiple failed appointments may result in being dismissed from the dental practice.

7. **Deposits and Refunds:** We may require a deposit at the time of scheduling major services such as crowns, bridges, dentures, surgical/periodontal procedures, implants, orthodontic treatment and other procedures that may require multiple visits. If you are reconsidering treatment that you have not yet received but have already paid for, you may cancel treatment and request a refund for the amount you paid. Once the office receives your refund request, you will receive a refund check within 30 days as per our Refund policy.

If you wish to discontinue treatment that has commenced, you are responsible for all costs we have incurred in preparing for your treatment (including, but not limited to, purchase of crowns, bridges, dentures, implants or other materials/appliances). In such cases, we will deduct incurred costs from the deposit you have paid. If the deposit does not cover incurred costs, we will bill you our Usual and Customary Rate for the service, if applicable.

Acknowledgement of Financial Policy: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

DATE: _____________

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN: ____

PRINT NAME OF PATIENT/PARENT/LEGAL GUARDIAN: ____

Dimensional Dental™

Name of the Patient: ____ Date of Birth (mm/dd/yyyy): _______________

SECTION A: NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

Purpose: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Consent: I, the undersigned, have had full opportunity to read the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

Signature of Patient/Parent/Legal Guardian: ____________________________________ Date: ___________________________________

Name of Parent/Legal Guardian: ____ Relationship to Patient: ______________________

Right to Revoke: You will have the right to revoke this Consent at any time by giving written notice of your revocation to the Privacy Officer listed in our Notice.

SECTION B: CONSENT FOR FAMILY MEMBER

Consent: I, the undersigned, understand that by signing this Consent form, I am giving my consent to disclose and discuss my protected health information with the following family member or friend, in order to carry out treatment, payment activities and health care operations

Name of Family Member or Friend: ____ Relationship: _________________________

Signature of Patient/Parent/Legal Guardian: ____________________________________ Date: __________________

Right to Revoke: You will have the right to revoke this Consent at any time by giving written notice of your revocation to the Privacy Officer listed in our Notice

SECTION C: CONSENT TO SHARE PATIENT RECORDS

Purpose: We are a member of a group of offices supported by Dimensional Dental Management, LLC. In the event that we need to refer you to another office supported by Dimensional Dental Management, LLC and you agree to the referral, we will transfer your patient records to facilitate your referral. Any such transfer of records will be performed free of charge. This is done as a convenience for you, and to ensure that you receive the best care possible. For more information on our supported offices, please ask the front desk or visit www.dimensionaldental.com

Consent: I, the undersigned, understand that, by signing this Consent form, I give consent to share my patient records with another office supported by Dimensional Dental Management, LLC, in the event that a referral is required and mutually agreed upon.

Signature of Patient/Parent/Legal Guardian: ____________________________________ Date: ___________________________________

SECTION D: CONSENT TO RECEIVE PATIENT NOTIFICATIONS

Purpose: In order to ensure that patients receive time-sensitive information and other informational healthcare messages, we send email and/or text notifications to patients. Signing this consent will indicate to us that you wish to opt-in to receive such notifications. You may opt-out of receiving these communications at any time. We will not impose a separate charge for these notifications but message/data rates may apply. It is important to note that certain communications, including, without limitation email and text message, which may contain your protected health information, are not invariably secure since certain communications can be intercepted, delivered and/or addressed to an unintended recipient, and/or improperly accessed while in storage and/or during transmission.

Consent: I, the undersigned, hereby consent to receive notifications, which may include my protected health information, by the following methods of communication that I have indicated below, with a full understanding of the risks involved with such notifications.

☐ Text: (_____)____ ☐ Please check here if you do not wish to receive voicemails at this number

☐ E-Mail: ____

☐ Opt-out of receiving text message ☐ Opt-out of receiving email communications

FOR OFFICE USE ONLY

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 the acknowledgement ☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify) ____

Signature of Office Staff: ____ Date: __________________________

You are entitled to a copy of the signed consent

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated. Please contact:
  Privacy Officer
  1030 Saint Georges Avenue, Avenel, NJ 07001
  Phone: 732-750-0707, Extension 1126

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal action

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your medical record. You can ask us to correct health information about you that you think is incorrect or incomplete. As us how to do this. We may say "no": to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full you can ask us not share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information on for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Chose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rates are violated

- You can complain if you feel we have violated your rights by contacting us using information on page 1.
- You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Visit https://www.hhs.gov/hipaa/filing-a-complaint/index.html, email OCRComplaint@hhs.gov or write to 200 Independence Avenue, S.W.
  Room 509F HHH Bldg.
  Washington, D.C. 20201
- We will not retaliate against you for filing a complaint

Your choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share

your information in the situations described below talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you were unconscious, we may go ahead and share information if we believe it is in your best interest. We may also share your information when needed to lessen any serious and eminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of Fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information to treat you and share it with other professionals who are treating you.
- Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
- Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do Research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or Federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with the Federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to the lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach that may have compromised the privacy or security of your information, occurs.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- Other Federal and state laws may require special privacy protections that limit the use and disclosure of certain health information about you. For example, such laws may include restrictions on the use and disclosure of genetic information, alcohol, and drug abuse information, HIV/AIDS, mental health, and sexually transmitted diseases. It is our intention to adhere to the more stringent legal requirement when this type of information is used or disclosed.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information on our responsibilities, see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available on our website and, upon request, at our office.

Effective Date: June 1, 2017
Revision Date: October 17, 2019