ROYAL DENTAL
THE CARE YOU DESERVE

Patient Information (Confidential)

Name _____ M F
First Middle Last Sex

Address _____ City _____

State ____ Zip _____ Email _____

SS# _____ Birthdate _____ Age ____

Phone: Home _____ Work _____

Check Appropriate Box: __ Minor __ Single __ Married
__ Divorced __ Widowed __ Separated

If College Student, __ Full time __ Part time

School Name _____ City _____ State ____

Patient's or Parent's Employer _____

Business Address _____

City _____ State _____ Zip _____

Spouse or Parent's Name _____

Employer _____ Work Phone _____

Emergency Contact _____

Phone _____

Dental Insurance Information Only

Name of Insured _____

Relationship to Patient _____ Home Phone _____

Birthdate _____ SS# _____

Date Employed _____ Employer Name _____

Union or Local # _____ Work Phone _____

Employer's Address _____

City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____

Ins. Group # _____ Policy / ID # _____

Ins. Co. Address _____ City _____

State _____ Zip _____ Max. Annual Benefit? _____

How much is your deductible? _____

How much have you used this year? _____

Do you have any additional insurance ____ Yes ____ No

Responsible Party

Name of Person Responsible For This Account _____

Relationship to Patient _____ Address _____

Home Phone _____ SS# _____ Driver's License # _____

Birthdate _____ Employer _____ Work Phone _____

Is this person currently a patient in our office? ____ Y ____ N

X _____ _____
Signature of Patient or Parent if Minor Date

Patient Medical History

Name_____ Age_____ Date_____

YES or NO

____ ____Are you in good health?
____ ____Have there been any changes in your general health within the past year?
Date of your last physical exam: _____
Physician's Name_____
Address_____
Phone No. _____
____ ____ Are you now under the care of a physician?
____ ____Have you ever been hospitalized for any surgical operation or serious illness?
Please explain, _____
____ ____Are you taking any medicines including nonprescription medicines?
If yes, what are you taking_____
_____
_____
____ ____ Bruise easily or abnormal bleeding?
____ ____ Have you ever required a blood transfusion
____ ____Have you had a recent unintended weight loss/gain
____ ____Have you ever needed deep cleaning/SRP?
____ ____Have you ever had bisphosphonate drugs (for Cancer or Osteoporosis)
____ ____Do you use tobacco? How much? Quit date?
____ ____ Do you or have you ever had history of alcohol or substance abuse?
____ ____Are you wearing contact lenses?
____ ____Have you been diagnosed with Gum disease?
____ ____Women: Are you pregnant?
____ ____Are you nursing?
____ ____Taking birth control pills

Are you allergic to or have you had serious reactions (other than stomach upset) to:
____ ____Local anesthetics like Novocaine
____ ____Penicillin or other antibiotics
____ ____Barbiturates, sedatives or sleeping pills
____ ____Aspirin or similar NSAIDs
____ ____Any metals
____ ____Latex / Rubber/ Adhesive
Other (please list) _____

Do you have or have you had the following:

Cardiovascular

____ ____ Rheumatic heart disease or fever
____ ____ Scarlet fever
____ ____ Heart defect/murmur, Mitral valve prolapse
____ ____ Stroke
____ ____ Heart surgery, trouble, attack, or angina
____ ____ Chest pain, shortness of breath
____ ____ High / low blood pressure
____ ____ Pacemaker
____ ____ Fainting or dizzy spells
____ ____ Anemia or blood disorders

Pulmonary

____ ____ Sinus issues
____ ____ Seasonal Allergies
____ ____ Lung or breathing problems
____ ____ Asthma or hay fever
____ ____ Tuberculosis, persistent or bloody cough
____ ____ COPD

Endocrine

____ ____ Hepatitis(A,B,C), jaundice or liver disease
____ ____ Stomach ulcer, reflux, IBS, Crohn's
____ ____ Hypoglycemia
____ ____ Kidney trouble
____ ____ Hives or skin rash
____ ____ Diabetes
____ ____ Thyroid problems

Neuromuscular

____ ____ Arthritis, rheumatism, fibromyalgia
____ ____ Epilepsy or seizures
____ ____ Back problems
____ ____ Chronic pain condition
____ ____ Cortisone treatment
____ ____ Glaucoma (Narrow/Wide)

Skeletal

____ ____ Joint replacement or any implants?
Date_____
____ ____ Head or neck trauma, whiplash

Systemic

____ ____ Sexually transmitted disease
____ ____ AIDS or HIV infection
____ ____ Lupus
____ ____ M.S.
____ ____ Cold sores / fever blisters

Cancer

____ ____ Chemotherapy for cancer or leukemia
What kind?
Diagnosis date?
____ ____Radiation
____ ____Surgery

Neurological

____ ____ Nervousness or phobias
____ ____ Chemical dependency, addictions
____ ____ Hypochondriasis
____ ____ Eating disorders, bulimia, anorexia
____ ____ ADHD
____ ____ OCD
____ ____ Bipolar/Schizophrenia
____ ____ Sleep disorder

____ ____Do you have any disease, condition or problem not listed? Please explain

Patient Dental History

Reason for this visit_____
Date of last dental visit_____What was done?_____
Previous dentist name / location_____
Date of last complete series of dental x-rays_____
Circle all that you are concerned about / currently have:
Sensitivity to: Hot Cold Sweets

Cavities	Fear of dentistry	Headaches
Gum disease	Clicking jaw	Want whiter teeth
Broken teeth	Loose teeth	Want to save teeth
Broken fillings	Spacing	Poor dentistry
Missing teeth	Grinding/clenching	Want gentle dentist
Dark/Ugly teeth	Snoring / Apnea	Recession
Crooked teeth	Bleeding gums	Cosmetic dentistry
Bad breath	Jaw or face pain	Nothing

Dental History

We would like to get to know you better…

I am changing dentists because:

Check any that apply

___ Recently moved into this area from_____

___ Dr/staff personality ___ Communication problem

___ Inadequate care ___ Fee concern ___ Insurance

___ Need a second opinion or better option on dental care

___ To find a dentist team who understands my needs

Where are you from originally? _____

Your occupation and job _____

Schools attended _____

Spouse's name & occupation _____

Children's names, ages _____

What's more fun than dental visits? _____

I have avoided dental care in the past because:

___ Fear of_____

___ Time commitment ___ No perceived need

___ Financial commitment ___ Trust factor

If you could change anything about your smile, what would you change?

_____

Are you interested in exploring (check any that apply):

___ Sleep apnea or Snoring Treatment Options to CPAP

___ Implants

___ I.V. Sedation and Sleep Dentistry

___ Oral Sedation(pill) and gas options

___ Smile Makeover -- Smile Analysis & Design

___ Why dental infections cause heart & other diseases

___ Ways to reduce or eliminate periodontal surgery (lasers)

___ Invisalign invisible orthodontic aligners

___ BriteSmile & ZOOM office whitening or home whitening

___ The best dental home care systems (CloSys)

How did you first hear about us? Check any that apply

___ Convenient location (Saw sign on the road)

___ Family member already comes here_____

___ Referred by a friend? Who?_____

___ I received your welcome letter/brochure in the mail

___ Yelp ___ Community Profiles Radio Show

___ Google.com ___ Other site(name) _____

___ Saw your Internet web site at Suwaneedental.com

___ Social media links: _____ Facebook ____ LinkedIn

___ Deserving Diva Contest ___ Free Dentistry Day

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to dental examination and any necessary records that are necessary for an accurate diagnosis. I authorize the dentist to use any treatment records, x-rays , models or photos for scientific, teaching or promotional purposes.

X_____Date_____

Signature of Patient or Parent if Minor

Sleep Disorder Questionnaire

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Situation Chance of Dozing (0-3)

1. Sitting and reading _____
2. Watching TV _____
3. Sitting, inactive in a public place (e.g. theatre or a meeting) _____
4. As a passenger in a car for an hour without a break _____
5. Lying down to rest in the afternoon when circumstances permit _____
6. Sitting and talking to someone _____
7. Sitting quietly after a lunch without alcohol _____
8. In a car, while stopped for a few minutes in the traffic _____

Total: _____

Interpretation:

0-7:It is unlikely that you are abnormally sleepy.

8-9:You have an average amount of daytime sleepiness.

10-15:You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.

16-24:You are excessively sleepy and should consider seeking medical attention

Doctor Notes:

- Health History Concerns
- Referrals
- Priorities
- Patient preferences

_____Date_____

Doctor signature

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Financial Policies

In order to accommodate the needs and requests of our patients, Royal Dental does file dental insurance. White we are pleased to able to provide this service to you, it is not possible for our staff to keep track of all individual requirements of each plan. Dental benefits plans will never pay for completion of your dental care; it is only meant to assist you. We are not contracted with all insurance companies. It is the insured person's responsibility to understand their benefits and confirm that our dental providers are in their network. Royal Dental can only provide an ***estimate*** of what your insurance will pay on a specific treatment and it is not a guarantee of payment. Secondary insurance can also be filed for our patients; however secondary insurance benefits are not taken into consideration when estimating coverage. If your insurance carrier pays a lesser amount than estimated, you will be billed for the difference.

✎ **Please initial on each line.**

_____ All co-payments, estimated co-insurance, and deductibles are due at the time of services, or before your procedures. We accept cash, major credit cards and outside payment financing only.

_____If your insurance company does not pay within 60 days, Royal Dental reserves the right to request payments in full for services from you and let you collect the insurance funds that are due to you.

_____It is your responsibility to provide us with your current address, telephone number, and insurance information at each visit. If you do not have proof of active insurance at your visit, you will be considered a self-pay patient for that visit and payments will be due in full that same day.

_____It is your responsibility to provide us with any legal documentation or divorce decree dictating a specific parent/guardian responsible for primary dental coverage.

_____If you do not inform us of any special requirements in your insurance contract, such as referral or pre-authorization for treatment and we subsequently complete services that are no covered, you will be billed directly for those charges.

In the event your account is turned over an outside agency for collections, your will be responsible for all collections fees, costs and such additional sums as the court may adjudge responsible.

Our team members will gladly assist you in filling our necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We welcome you to our family and look forward to helping you get the healthy, beautiful smile you have always wanted

I,_____, have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Royal Dental.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number.

_____ _____

Patient Signature (parent if child) **Date**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ {Please Print Name}	_____ Relationship
_____ {Please Print Name}	_____ Relationship
_____ {Please Print Name}	_____ Relationship

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____

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Broken Appointment Policy

We attempt to make confirmation calls, send texts, as well as emails at least 48 hours in advance of your scheduled appointment as a courtesy. We will leave reminder messages on your answering machine/voicemail if you have one. Therefore, we ask that our patients kindly give us a 24-hour notice if there is a need to cancel or reschedule an appointment. We reserve the right to cancel/reschedule an appointment if not confirmed by the patient. A one-time consideration will be made for failure to give notice. Any cancelation or no shows after that will be charged a **$75.00 fee**.

Thank you for your understating of this matter, as we strive to provide the best quality care for our patients.

I have ready the above Broke Appointment Policy, and I understand that I will be charged if I fail to show up for my scheduled appointment.

_____

Patient Name (Printed)

_____

Patient Signature (Parent if child)

_____

Date

E-Mail Consent Form

Disclaimer

E-mail messages contain confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy any e-mail received from Royal Dental. Please notify the ender immediately should you have received any e-mail by mistake.
E-mail transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, or omissions in the contents of this message, which arise as a result of e-mail transmission.
If verification is required, please request a hard copy version.
By signing this form, you also consent to Royal Dental leaving messages on your cell/home phone about treatments, finances, and any lab results.

Your Acknowledgement and Agreement

I,_____, acknowledge that I have received the E-mail Consent Form and consent to leave messages on recorder in reference to my appointments, treatments, finances, and any lab results. I understand the risks associated with the communication of e-mail between Royal Dental and myself. I consent to the conditions outlined in the Disclaimer. In addition, I agree to the instructions outlined in the disclaimer, as well as any other instructions Royal Dental may impose to communicate with patients by e-mails.

E-mail address:_____

_____
Patient Signature (Parent if Child)

_____
Witness Signature

_____
Date

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Consent/Authorization for Dental Treatment of A Minor

Patient Name:_____ Date of Birth:_____

All minors seeking dental treatment must be accompanied by a parent/legal guardian during the initial visit. After the initial appointment, a minor may by seen for treatment only with written authorization from the parent/guardian under the condition specified in this consent. If the parent/legal guardian cannot attend the appointment, the following instructions that you select will be adhered to in the treatment of the minor patient (check all that apply):

☐ the consent for to be sign any and all forms required to give permission to Sina Sadeghi DDS at Royal Dental to treat the dental needs of my child,

☐ the consent to the dental practice to discuss finances (treatment charges, account balances, next visit charges),

☐ the consent to dental practice to discuss my child's future dental treatment needs (ie. Treatment plans),

☐ the consent to sign my child's treatment plant once it has been presented by the dental staff. I understand this does not obligate me to the treatment, only that the office has informed me or my representative of the dental needs of my child,

☐ the consent to the schedule future dental visits for my child.

If you need to send your child to their appointment with an adult other than yourself/legal guardian, please complete this section.
I appoint the following adult_____, whose relationship to the minor is_____, to consent to dental treatment which is deemed necessary by Sina Sadeghi DDS/Royal Dental as authorized herein. A parent/legal guardian may appoint another adult to accompany the minor patient to the appointment. If the parent/legal guardian is not available, the Texas Family Code allows only certain adults to consent for medical treatment to minors if parental consent cannot be obtained. These are: a grandparent, an adult brother, sister, aunt or uncle, any adult who has actual care, control, and possession of the minor and has written authorization to consent from the parent/legal guardian.

I,_____, am the parent/legal guardian of the minor child_____. I have the legal right to consent for medical/dental treatment for this patient. I hereby authorize Sina Sadeghi DDS/Royal Dental to provide dental treatment as indicated above. **I understand this consent will be valid for one year or until I rescind this agreement in writing.**

I understand I am responsible for all charges or fees incurred and co-payments must be made at the time of service as Royal Dental financial policy states.

_____ _____ _____

Parent/Legal Guardian Signature **Parent/Legal Guardian Printed Name** **Date**

Royal Dental

Notice of Electronic Disclosure

Notice of Electronic Disclosure of Protected Health Information

If Dr. Sina Sadeghi obtains or creates information about your health, Royal Dental is required by law to protect the privacy of your information. Protected Health Information (PHI) includes any information that relates to:

- Your past, present, or future physical or mental health or condition;
- Health care provided to you; and,
- Past, present, or future payment for your health care.

Dr. Sadeghi may not disclose your PHI electronically without your authorization unless allowed by law. For example, we may share your PHI through approved, secure electronic methods for the purpose of treatment, payment for health care services, or health care operations such as case management or care coordination.

Dr. Sadeghi may also need to share your PHI electronically for public health purposes such as preventing and controlling the spread of infectious diseases or for certain disaster relief efforts.

For a complete list of reasons that Dr. Sadeghi is allowed by law to share your PHI, please refer to Royal Dental's Notice of Privacy Practices.

If you believe Dr. Sadeghi has violated the obligations described in this notice, you have the right to file a complaint with our Privacy Officer or with the Texas Attorney General's Office.

Royal Dental

Notice of Privacy Practices

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

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is Jim Moore - 469.342.8300, Extension 508

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by Federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for procedures may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and staff training.

For example, we may disclose your protected health information to interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses. We may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "Business Associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a Business Associate involves the use or disclosure of your protected health information, we will have a written agreement with that Business Associate that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. We may also send you information about products or services that we believe may be beneficial to you. You may request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made With Your Written Authorization

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

For example, with your written, signed authorization, we may use your demographic information and the dates that you received treatment from our office, as necessary, in order to contact you for fundraising activities supported by our office.

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable Federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Workers' Compensation: We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please ask your doctor if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

You may request a restriction by presenting your request, in writing to a staff member in our office. The staff member will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff member provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

You may have the right to have your doctor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please ask your doctor if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limits.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, to the Texas Attorney General's Office, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Jim Moore, a Certified HIPAA Professional. You may contact our Privacy Officer in writing at our office address or by calling 469.342.8300, Extension 508. Our website may offer additional information about the complaint process.

This notice was published and becomes effective on November 1, 2017.

Royal Dental

Acknowledgement of Receipt
Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices
Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your Protected Health Information.
Our office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I give permission for the use and disclosure of my health information as set forth above.

Patient or Legally Authorized Individual Signature

Date Time

Print Patient's Full Name _____

Witness Signature

Date Time