



Soomin Richard Kim, D.D.S., M.P.H.
6452 Broadway Blvd.
Garland, TX 75043
Phone: 972.226.6947 Fax: 972.226.6608

Name of Patient _____ Date _____

Address _____ Apt. _____ City _____

State _____ Zip _____ Home Phone _____ Cell Phone _____

If minor, Name of Guardian _____ Guardian's Phone _____

Employer _____ Occupation _____

Business Address _____

Business Phone _____ Email _____

Patient's SS# _____ DL# _____

DOB _____ Married/Single/Partner _____ Gender _____

Spouse's Name _____ Spouse's Cell Phone _____

Spouse's Employer _____ Spouse's Occupation _____

Responsible Party (if not patient) _____

Emergency Contact _____ Cell Phone _____

Names of other family members who are patients _____

How did you find out about our office? _____

Dental Insurance

| PRIMARY | Secondary |
|-------------------------|-------------------------|
| Insurance Company _____ | Insurance Company _____ |
| Name of Insured _____ | Name of Insured _____ |
| ID/SS# _____ | ID/SS# _____ |
| Insurance Phone # _____ | Insurance Phone # _____ |
| Employer _____ | Employer _____ |
| Group # _____ | Group# _____ |

Important Notice: Please be aware that insurance verification tells us only that you have a policy in force. It DOES NOT tell us how much the insurance will pay for certain procedures. Predetermination of benefits is likewise not a guarantee of payment. The payable benefits can only be determined after your insurance company has received and processed your claim. Accordingly, regardless of the amount collected at the time of service, you are responsible for the full amount of charges relating to all services rendered. If you have any questions regarding the coverage of our services, you must contact your insurance carrier. Your insurance coverage is a contract between you and your carrier. Only they can control the amounts paid on your behalf.



DENTAL ONCOLOGY PROFESSIONALS

PERSONAL HEALTH HISTORY

as of _____
(today's date)

Patient name: _____ Date of birth: _____

Please answer the following questions to the best of your ability by checking the box that is appropriate for you. Knowing this information is critical in providing you the very best personal care you deserve. Please answer each question thoughtfully, and do not hesitate to ask a team member to clarify any item you do not understand. Thank you for your co-operation.

MEDICAL HISTORY

| | Yes | No | Don't Know |
|---|--------------------------|--------------------------|--------------------------|
| Have there been any major changes in your health within the past year? <i>If yes, please explain:</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you under the care of a physician or currently receiving medical care? <i>Name of physician: _____ Physician's phone: _____</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any artificial joints, heart valves, or limb prostheses? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been diagnosed with mitral valve prolapse with regurgitation? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a pacemaker? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you the recipient of a solid tissue organ transplant (e.g. lung, heart, kidney, etc.)? <i>If yes, which organ? _____ When? _____</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever received a bone marrow or hemopoietic stem cell transplant? <i>If yes, when?</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told you need to be premedicated prior to dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you currently have a port, mediport, or other venous catheter? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever received or are you currently receiving bisphosphonate therapy? <i>If yes, please circle.: Zometa Denosumab Xgeva Prolia Reclast Aredia Fosamax Boniva Other</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>For women only:</i> Are you pregnant? <i>If yes, due date:</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>For women only:</i> Are you currently breastfeeding? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Patient name: _____ Today's date: _____

ONCOLOGY:

| | Yes | No | Don't Know |
|--|--------------------------|---------------------------------|--------------------------|
| Have you ever been diagnosed with some type of cancer? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, please complete this section. If no, please proceed to MEDICATIONS section.</i> | | | |
| Type of cancer: | Stage, if known: | | |
| Will/Did your cancer treatment include surgery? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Will/Did your cancer treatment include radiation therapy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, dates of treatment:</i> | | | |
| Will/Did your cancer treatment include chemotherapy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, dates of treatment:</i> | | <i>Type of chemo, if known:</i> | |
| Will/Did your cancer treatment include immunotherapy or biological therapy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, dates of treatment:</i> | | <i>Type, if known:</i> | |
| Do you currently have a PEG/feeding tube? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

MEDICATIONS:

| | Yes | No | Don't Know |
|--|--------------------------|--------------------------|--------------------------|
| Are you taking any prescription, over-the-counter medication, or supplement? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please list all medications you are taking. Include prescriptions, over-the-counter medications, and vitamin/mineral/nutraceuticals. If necessary, please check box and continue on back of page.

MEDICATION

DOSAGE

FREQUENCY

ALLERGIES:

| | Yes | No | Don't Know |
|-------------------------------------|--------------------------|--------------------------|--------------------------|
| Are you allergic to any medication? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any other allergies? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please list all allergies and explain reaction. If necessary, please check box and continue on back.

ALLERGY

REACTION

Patient name: _____ Today's date: _____

SOCIAL:

| | Yes | No | Don't Know |
|---|--------------------------|--------------------------|--------------------------|
| Do you use tobacco? <i>If yes, what kind? How much?</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink alcohol? <i>If yes, how many drinks per week? (One drink = 1 oz. liquor/5 oz. wine/12 oz. beer)</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you used any illegal drug within the past year? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever found it difficult to quit taking a prescription medication? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

Do you currently have -OR- have you ever had any of the following diseases, conditions, or issues?

LUNG/BREATHING ISSUES (RESPIRATORY SYSTEM):

| | Yes | No | Don't Know |
|---|--------------------------|--------------------------|--------------------------|
| Hay fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent cough | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Positive test/treatment for tuberculosis (TB) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Seasonal allergies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic obstructive pulmonary disease (COPD) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coughing up blood | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other respiratory/breathing/lung issues | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

HORMONE/GLAND ISSUES (ENDOCRINE SYSTEM):

| | Yes | No | Don't Know |
|---|--------------------------|--------------------------|--------------------------|
| Diabetes <i>(If yes, circle appropriate.)</i> Type 1 Type 2 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, is diabetes well-controlled? Recent A1C: Recent blood glucose:</i> | | | |
| Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other hormone/gland/endocrine issues | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

Patient name: _____ Today's date: _____

HEART/VASCULAR ISSUES (CIRCULATORY SYSTEM):

| | Yes | No | Don't Know |
|--|--------------------------|--------------------------|--------------------------|
| Heart attack <i>If yes, when?</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure <i>If yes, is condition controlled?</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain (Angina) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Atherosclerosis / Coronary Artery Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bypass surgery/stent placement <i>If yes, when?</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other heart/circulatory/vascular issues | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

BLOOD ABNORMALITIES:

| | Yes | No | Don't Know |
|---|--------------------------|--------------------------|--------------------------|
| Bleeding problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood clots / Deep vein thrombosis (DVT) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking blood thinners? <i>If yes, what is your recent PT/INR result, if known.</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other blood/bleeding issues | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

LIVER ISSUES (HEPATIC SYSTEM):

| | Yes | No | Don't Know |
|---|--------------------------|--------------------------|--------------------------|
| Hepatitis <i>(If yes, circle appropriate.)</i> Type A Type B Type C When? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcoholic liver disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other liver/hepatic issues | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

Patient name: _____ Today's date: _____

KIDNEY ISSUES (RENAL SYSTEM):

| | | Yes | No | Don't Know |
|---------------------------|--------------------------------|-----|----|------------|
| Kidney disease | <i>If yes, which stage?</i> | | | |
| Currently on dialysis | <i>If yes, on which days?:</i> | | | |
| Other kidney/renal issues | | | | |

Comments: _____

STOMACH/DIGESTIVE ISSUES (GASTROINTESTINAL SYSTEM):

| | | Yes | No | Don't Know |
|---|--------------------------------------|-----|----|------------|
| Stomach pain | | | | |
| Frequent heartburn | | | | |
| History of ulcers | | | | |
| Colitis, Irritable Bowel Syndrome (IBS), or Crohn's disease | <i>Please circle, if applicable.</i> | | | |
| Frequent vomiting | | | | |
| Other stomach/digestive issues | | | | |

Comments: _____

MUSCLE/BONE/JOINT ISSUES (MUSCULOSKELETAL SYSTEM):

| | | Yes | No | Don't Know |
|-------------------------------------|--------------------------|-----|----|------------|
| Joint/back pain | | | | |
| Joint swelling | | | | |
| Rheumatoid arthritis | <i>If yes, location:</i> | | | |
| Osteoarthritis | <i>If yes, location:</i> | | | |
| Temporomandibular joint dysfunction | | | | |
| Other muscle/bone/joint issues | | | | |

Comments: _____

NEUROLOGIC ISSUES (CENTRAL NERVOUS SYSTEM):

| | | Yes | No | Don't Know |
|--|--|-----|----|------------|
| Epilepsy / Seizure disorder | | | | |
| Chronic headaches | | | | |
| History of head injury | | | | |
| Numbness of arms, legs, hands, or feet | | | | |
| Fainting spells / syncope | | | | |

Patient name: _____ Today's date: _____

NEUROLOGIC ISSUES (CENTRAL NERVOUS SYSTEM) cont'd:

Yes No Don't Know

| | | | |
|-------------------------|--------------------------|--------------------------|--------------------------|
| History of stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain: | | | |

Comments: _____

GENITOURINARY ISSUES (GENITOURINARY SYSTEM):

Yes No Don't Know

| | | | |
|---|--------------------------|--------------------------|--------------------------|
| Frequent urinary tract infections (UTI) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Venereal disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain: | | | |
| <i>For women only:</i> Vaginal yeast infection with antibiotics use | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>For women only:</i> Post-menopausal | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>For men only:</i> Erectile dysfunction (ED shown to be associated with oral bacteria.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

IMMUNE/AUTOIMMUNE ISSUES (IMMUNE SYSTEM):

Yes No Don't Know

| | | | |
|--|--------------------------|--------------------------|--------------------------|
| HIV / AIDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Immune system disorders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sjögren's syndrome | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Psoriasis / Eczema / Rosacea <i>Please circle appropriate.</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other autoimmune issues | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, please explain in detail.:</i> | | | |

Comments: _____

MENTAL HEALTH:

Yes No Don't Know

| | | | |
|--------------------------------------|--------------------------|--------------------------|--------------------------|
| Depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other mental health issues/disorders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

OTHER:

Yes No Don't Know

| | | | |
|---|--------------------------|--------------------------|--------------------------|
| Do you have any other disease, condition, or issue not listed or reported thus far? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, please explain in detail.:</i> | | | |

Comments: _____

Patient name: _____ Today's date: _____

DENTAL AND ORAL HEALTH HISTORY

| | Yes | No | Don't Know |
|--|--------------------------|--------------------------|--------------------------|
| Are you having any dental discomfort at this time? <i>If yes, please explain:</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had serious trouble with previous dental work? <i>If yes, please explain:</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Does having dental work make you nervous? <i>If yes, please mark on scale: Slightly nervous _____ Extremely nervous</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever experienced any abnormal bleeding after a dental procedure? <i>If yes, please explain:</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you previously been diagnosed with gum disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Date of your last dental visit: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Date of your last dental cleaning: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Name of previous dentist: _____ Location: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How often do you brush your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How often do you floss your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had braces? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had gum surgery? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you feel like your mouth is dry? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear a denture or partial denture? <i>If yes, does it fit well?</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you happy with the appearance of your teeth? <i>If no, what would you change?</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

I understand that, to the best of my knowledge, all of the preceding answers are true and correct. I understand if I ever have any changes in my health or in the medications I am taking, I must inform your office immediately. I hereby give my consent of treatment for myself or the named patient (of whom I am the parent, legal guardian, or foster parent) to Dr. Dennis Abbott and Dental Oncology Professionals.

Signature of Patient or Guardian: _____ Date: _____

Signature of Dentist / Hygienist: _____ Date: _____

Dental Oncology Professionals
Dr. Kim and Staff

Informed Consent

The undersigned hereby authorizes Doctor or his staff to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I authorize Doctor to perform treatment that may be indicated, understanding that it is my right to approve or deny said diagnosed treatment after discussion of the risks and benefits involved. I also understand the use of anesthetic agents embodies a certain risk. I understand that I am responsible for payment for dental services, and that this payment is due at time services are rendered. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 90 days. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney's fees as may be required to effect collection of the note.

I authorize the use of all images for educational and professional purposes.

I further authorize the release of information to the insurance carrier(s) and authorize payment directly to the Doctor.

I am aware a 24 hour notice is required to cancel appointments. If the courtesy of one full BUSINESS day is not given to change an existing appointment, the office reserves the right to assess a cancellation charge of \$50.00 per hour, that was scheduled.

Patient Signature: _____ Date: _____

Guardian Signature (if patient is under age 18): _____

Dental Oncology Professionals
Dr. Kim and Staff

IMPORTANT NOTICE

Please note: Dr. Soomin Richard Kim is OUT-OF-NETWORK with ALL insurance companies.

When you make an appointment with our office, the insurance verification information that is available to us tells us ONLY that you have a policy in force. The verification process CANNOT tell us if your insurance will pay or how much it may pay for the service you have received. Predetermination of benefits is likewise NOT a guarantee of payment. The payable benefit can only be determined AFTER your insurance company has received and processed your claim.

Accordingly, REGARDLESS of the amount collected at the time of the appointment, you are responsible for the FULL amount of charges relating to all services rendered.

If you have ANY questions regarding to the coverage of our services, you must contact your insurance company. Your insurance coverage is a contract between you and your carrier. Only they can control the amounts paid on your behalf.

Assignment and Release

I certify that I have insurance coverage with _____ and assign directly to Dr. Soomin Richard Kim all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits for related services.

I certify that I am responsible for services not paid by my insurance company and also will pay any late fees, collection cost or legal fees on my account that is delinquent past 90 days.

Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Dental Oncology Professionals
Dr. Kim and Staff

ELECTRONIC INFORMATION UPDATE

Please print your name and email address on this form and sign the notice at the bottom of the page.

Name: _____

Email: _____

Alt. Email: _____

I understand that by providing my email address, electronic communication will be limited to correspondence from the office of Soomin Richard Kim, D.D.S., M.P.H. and falls within the guidelines of HIPAA. I further understand that under no circumstances will my private information, including my email address, be given to a third party without my written consent.

Signature _____ Date: _____

Dental Oncology Professionals
Dr. Kim and Staff

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY POLICY

"You may refuse to sign this acknowledgement"

I, _____ have been informed of this office's Notice of
Privacy Policies.

Print Name

Signature

Date

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)

Soomin Richard Kim, DDS,
MPH
6452 Broadway Blvd
Garland
Texas, 75043

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL 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 AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at Soomin Richard Kim, DDS, MPH understand that medical information about you and your health is personal. Applicable federal and state law requires us to maintain the privacy of your health information. We are also required 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 that are described in this Notice while it is in effect. This Notice takes effect 10/12/21, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. 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. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment For Services: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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 any time; your revocation will not affect any use 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.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or another person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

Marketing Health-Related Services: We will not use your health information for marketing purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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 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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages or letters).

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 obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, mailing, and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format,

of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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