East Taylor Dental Associates
family, cosmetic & implant dentistry

Welcome to our practice! We are dedicated to performing high quality dental care using the latest dental technology advancements in a caring and friendly environment; providing our patients with a uniquely positive dental experience. We thank you for choosing to be a part of our dental practice and welcome your referrals of family and friends.

The registration process can be streamlined by sending your completed paperwork in advance. Please choose one of the following methods to submit your registration:

- EMAIL: registration@easttaylordental.com
- FAX: (334) 271-4709
- MAIL: 2201 Taylor Road, Montgomery, AL 36117

You may also attach a copy of your insurance card and photo identification or bring it with you to your appointment. If you have any questions, please do not hesitate to call (334) 271-4600. We are looking forward to seeing you soon!

East Taylor Dental, PC
2201 Taylor Road
Montgomery, AL 36117
www.easttaylordental.com
(334)271.4600 Phone (334)271.4709 Fax

EAST TAYLOR DENTAL, PC - PATIENT REGISTRATION INFORMATION

ID: _____ Salutation: ☐ Miss ☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr.

First Name_____ Last Name _____Middle Initial ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (If someone other than patient)

First Name: _____Last Name: _____Middle Initial ____

Address: _____Address 2: _____

City, State, Zip _____

Home Phone: _____Work Phone: _____ Ext _____ Cell: _____

Birthdate: _____Soc Sec #: _____Drivers Lic # _____

Employer: _____ Employer Phone: _____

☐ Responsible Party is also an Insurance policy holder for patient ☐ Primary Insurance ☐ Secondary Insurance

Patient Information

Address: _____ Address 2:_____ _____

City, State, Zip _____

Home Phone: _____Work Phone: _____ Ext _____ Cell: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birthdate: _____Age _____Social Security #: _____/____/_____ Drivers Lic #_____

E-mail: _____ ☐ I would like to receive correspondence by: ☐ E-mail ☐ Text

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Applicable

Employer Name: _____ Employer Phone: _____

Address: _____City, State, Zip _____

Student Status: ☐ Full Time ☐ Part Time Name of School: _____

Address: _____City, State, Zip _____

Preferred Pharmacy: _____Location/Address: _____

ER Contact: _____ER Phone: _____Your Best # from 8 am-5pm_____

Spouse Information

First Name: _____ Last Name _____Middle Initial_____

Address: _____ City, State, Zip _____

Home Phone: _____Work Phone:_____Ext____ Cell:_____Social Security____/___/_____

Employer: _____ Employer Phone: _____ Sex: ☐ Male ☐ Female

EAST TAYLOR DENTAL, PC - INSURANCE REGISTRATION

PRIMARY DENTAL INSURANCE INFORMATION:

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Social Security #_____/_____/_____ Insured's Date of Birth: _____/_____/_____

Employer: _____ Telephone: _____

Address: _____ City, State, Zip: _____

Insurance Company: _____ Telephone: _____

Address: _____ City, State, Zip: _____

Subscriber/Contract Number: Group Number:

SECONDARY DENTAL INSURANCE INFORMATION:

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Social Security #_____/_____/_____ Insured's Date of Birth: _____/_____/_____

Employer: _____ Telephone: _____

Address: _____ City, State, Zip: _____

Insurance Company: _____ Telephone: _____

Address: _____ City, State, Zip: _____

Subscriber/Contract Number: _____ Group Number: _____

PRIMARY MEDICAL INSURANCE INFORMATION:

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Social Security #_____/_____/_____ Insured's Date of Birth: _____/_____/_____

Employer: _____ Telephone: _____

Address: _____ City, State, Zip: _____

Insurance Company: _____ Telephone: _____

Address: _____ City, State, Zip: _____

Subscriber/Contract Number: _____ Group Number: _____

SECONDARY MEDICAL INSURANCE INFORMATION: (Abbreviated)

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Social Security # _____/_____/_____ Insured's Date of Birth: _____/_____/_____

Employer: _____ Telephone: _____ Address: _____

Insurance Company: _____ Telephone: _____ Address: _____

Subscriber/Contract Number: _____ Group #: _____ Do companies coordinate benefits? ☐ Yes ☐ No

Time 10:49 AM

East Taylor Dental, P.C.

Date 1/13/2014

Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	If yes
Do you use tobacco?	○ Yes ○ No	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Yellow Jaundice ○ Yes ○ No	Snoring ○ Yes ○ No	Sleep Apnea ○ Yes ○ No	

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

EAST TAYLOR DENTAL, P.C. – PATIENT MEDICATION LIST

PATIENT NAME: _____ **ACCT #**_____ **DATE:** _____

Prescription Medications (Include Vitamins, Herbs & Over the Counter Medications)	**Prescribed Dosage**	**Frequency & When Taken** (AM/Noon/PM)	**Name of Prescribing Doctor**	**Condition or Reason for taking Medication**	**For Office Use Only**
Ex: Nexium	40mg	One dose per day @ bedtime	Dr. Feel Good	Peptic Ulcer	

To the best of my knowledge, the above listed medications etc. are accurate for this patient. I understand that providing incorrect information can be dangerous to this patient's health. Signature of Patient or Parent of Patient: _____

(If medications extend beyond this page, please complete a second form)

EAST TAYLOR DENTAL, P.C.
DENTAL HISTORY

Patient Name	
Date of Birth	**Medical Alert**

Welcome! *So that we may provide you with the best possible care please complete both sides of this form. It is important that we know about your Medical and Dental History. These facts have a bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank You for taking the time to completely fill out this questionnaire!*

What is the reason for your visit today? _____
Date of Last Dental Visit _____ ***Last Dental Cleaning*** _____ ***Full Mouth X-Rays*** _____
What was done on your last dental visit? _____
Previous Dentist's Name _____ ***Telephone:*** _____
Address _____ ***City, State, Zip*** _____
How often do you have dental examinations? _____
How often do you brush your teeth? _____ ***How often do you floss?*** _____ _____
What other dental aids do you use? (Interplak, toothpick, etc.) _____
Do you have any dental problems now? ***Yes*** ***No*** ***(If yes, please describe:*** _____

Are any of your teeth sensitive to:		
Hot or cold?	*Yes*	*No*
Sweets?	*Yes*	*No*
Biting or Chewing?	*Yes*	*No*
Have you noticed any mouth odors or bad tastes?	*Yes*	*No*
Do you frequently get cold sores, blisters, or any other oral lesions?	*Yes*	*No*
Do your gums bleed or hurt?	*Yes*	*No*
Have your parents experienced gum disease or tooth loss?	*Yes*	*No*
Have you noticed any loose teeth or change in your bite?	*Yes*	*No*
Does food tend to become caught in your teeth?	*Yes*	*No*
If yes, where? _____		
Do you:		
Clench or grind your teeth while awake or Asleep?	*Yes*	*No*
Bite your lips or cheeks regularly?	*Yes*	*No*
Hold foreign objects with your teeth?	*Yes*	*No*
(pencils, pipe, pins, nails, fingernails)	*Yes*	*No*
Mouth breathe while awake or asleep?	*Yes*	*No*
Have tired jaws, especially in the morning?	*Yes*	*No*
Smoke or chew tobacco?	*Yes*	*No*
Have frequent heavy snoring?	*Yes*	*No*
___Which effects the sleep of others?	*Yes*	*No*
Have significant daytime drowsiness?	*Yes*	*No*
Have night time choking spells?	*Yes*	*No*
Been told that "I stop breathing" when Sleeping?	*Yes*	*No*
Gasping when waking up?	*Yes*	*No*

Have you ever had:		
Orthodontic treatment?	*Yes*	*No*
Oral Surgery?	*Yes*	*No*
Periodontal treatment?	*Yes*	*No*
Your teeth ground or bite adjusted?	*Yes*	*No*
A bite plate or mouth guard?	*Yes*	*No*
A serious injury to the mouth or head?	*Yes*	*No*
If so, please describe, including cause _____		
_____		
Have you experienced:		
Clicking or popping of the jaw?	*Yes*	*No*
Pain? (joint, ear, side of face)	*Yes*	*No*
Difficulty opening or closing your mouth?	*Yes*	*No*
Difficulty chewing on either side of the mouth?	*Yes*	*No*
Are you satisfied with the appearance of your teeth?		
Would you like to keep your teeth all of your life?	*Yes*	*No*
Do you feel nervous about having dental treatment?	*Yes*	*No*
If so, what is your biggest concern? _____		
_____		
Have you ever had an upsetting dental experience?	*Yes*	*No*
If yes, please describe _____		

Is there anything else about having dental treatment that you would like us to know? ***Yes*** ***No***
_____

EAST TAYLOR DENTAL, P.C.
OFFICE POLICY
Killian J. Horner, DDS
Jennifer D. Ahn, DMD

Welcome to our practice! We are dedicated to performing high quality dental care using the latest dental technology advancements in a caring and friendly environment; providing our patients with a uniquely positive dental experience. We thank you for choosing to be a part of our dental practice and welcome your referrals of family and friends.

We are concerned about the cost of your dental care and want to address some current issues related to the cost of dental services. Considerable care has been taken in setting our fees. Every effort has been made to insure that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care. Please take a moment to review our policies. Please ask all questions before signing. Thank you.

APPOINTMENTS

- Once an appointment is made, please remember this time is reserved specifically for you.
- **If you must change your appointment time, East Taylor Dental Associates requires a forty-eight (48) hour, (at least 2 full business days) notice on any cancellation or re-scheduled appointment. (Legitimate emergencies are an exception.)**
- We reserve the right to assess a fee for the time reserved for an appointment in which a 2 business day's cancellation notice is not given, as stated above. This fee can range from a minimum of $25.00 to $125.00/half hour, based on the complexity of services to be performed at your time of visit.
- Cancellation or appointment changes must be handled by a staff member and not via our voicemail system.

INSURANCE

- If you have dental insurance coverage, East Taylor Dental Associates will file your dental claims as a courtesy to you.
- Please be aware that all professional services rendered are charged directly to the Patient/Responsible Party and the Patient/Responsible Party is personally responsible for payment of fees.
- We DO NOT render our services on basis that insurance companies will pay all of our fees.
- All patient co-payments and deductibles, as required by your specific insurance

coverage, are due and payable at the time of EACH visit.

- You are responsible for providing us with accurate insurance information at the time of service. Failure to do so could result in your claim being rejected or delayed. Repeated filing of duplicate insurance claims due to inaccurate or inadequate information provided by you may be subject to a re-filing fee of $10.00 per claim.
- If payment for your claim has not been received within 45 days from the time when the claim was filed to your insurance company, you, the Patient/Responsible Party, will be responsible for any unpaid balance.
- If your insurance company pays less than the estimated benefit, you will be responsible for the remaining balance.
- If your insurance company pays more than the estimated benefit, you may have a credit balance on your account. Per your request, you may leave the credit on your account for future care or you may request a refund. East Taylor Dental Associates will make every effort to process refunds within five (5) business days from the date the request is received. Please keep your personal information up to date, as a verifiable address must be available for us to mail checks.
- East Taylor Dental Associates will make every effort to minimize bookkeeping errors. In the event that an error should occur, we will do our best to refund any credits as stated above. Should the error result in a debt owed to us, we will provide a corrected statement and will allow forty-five (45) days for payment to be rendered in full.

PAYMENT AGREEMENT

- For and in consideration of the provision of services, I accept the fee charged as a lawful debt and promise to pay said fee in full for all services at the time services are rendered.
- We accept cash, personal checks, MasterCard, Visa, American Express, or Discover Card. We do not accept post-dated checks.
- Extended payment plans and interest free financing plans are available through Care Credit and Spring Stone Financial.
- In the event payment is not received by the agreed upon dates, I understand a 1 ½% finance charge (18% APR) will be added to my account and my account is subject to a $10.00 rebilling fee per each monthly statement.

COLLECTIONS

- East Taylor Dental Associates reserves the right to assess a service charge of $30.00 for all returned checks. (Or the maximum allowed by law.)
- East Taylor Dental Associates also reserves the right to forward any and all accounts over 90 days past due to an outside collections agency.

- I agree to pay any cost accrued in the collection of my account, including the cost of the collection agency (33.33% of overdue balance), reasonable attorney fees and court costs, if such should be necessary.
- **EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:** You agree, in order for us to service your account or to collect monies you may owe, East Taylor Dental, P.C. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could results in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.
- I waive all rights of exemption under the Constitution and laws of the State Alabama, and any other state.
- I further authorize East Taylor Dental Associates to receive and exchange credit information.

I hereby authorize release of medical information for insurance claims and payment of my group insurance benefits, otherwise payable to me, to the dentist. I/We have read this disclosure and agree that East Taylor Dental, P.C., its employees and/or agents may contact me/us described above. I further agree to accept and adhere to the above office policy of East Taylor Dental Associates.

ACKNOWLEDGEMENT OF RECEIPT
I acknowledge that I received a copy of the ETD Office Policy.

Print Patient Name: _____

Print Parent/Guardian Name (if under the age of 19): _____

Signature: _____

Date: _____

EAST TAYLOR DENTAL, P.C.
OFFICE POLICY
Killian J. Horner, DDS
Jennifer D. Ahn, DMD

INFORMED CONSENT FOR TREATMENT

- I hereby authorize the dentist to designate staff to take x-rays, study models, photograph's and any other diagnostic aids deemed appropriate by the dentist to make a through diagnosis of myself or my dependents dental needs. Upon such diagnosis, I understand a treatment plan will be formulated. From this treatment plan, I will be provided with an estimate of the cost of the treatment. However, I understand that this is only an ESTIMATE.

- I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

- I also understand that, during the course of the procedure(s), unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those originally planned. I therefore authorize and request that the doctors and staff of East Taylor Dental Associates perform such procedures as are necessary and desirable in the exercise of sound professional judgment.

- I understand that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications. Possible complications in general dentistry includes, but are not limited to:

  1) Post-operative discomfort and swelling which may necessitate several days of home recuperation.

  2) Injury to adjacent teeth and fillings.

  3) Post-operative infection requiring additional treatment.

  4) Stretching of the corners of the mouth with resultant cracking and bruising.

  5) Restricted mouth opening for several days or weeks.

  6) Injury to the nerve underlying the teeth during anesthesia (shots) or extractions resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue on the operated side; this may persist for several weeks, months or in rare instances, permanently.

  7) Discoloration at the injection site or in rare cases, bruising of the cheek close to the injection site.

  8) Exposure of the nerve while preparing the tooth for a filling or crown.

  9) The need for root canal therapy after restorative work (e.g. fillings, crown) resulting from deep restorations or stress caused by multiple restorations to the same tooth.

- I agree to the use of anesthetics, sedative and other medications as necessary.
- I understand that it is important for me to understand the treatment being rendered, pros and cons of that treatment, and any possible alternative treatments.
- I understand that if I do not understand the proposed treatment, it is better to ask any questions I have before treatment is started.

PHOTO RELEASE

The doctors and staff of East Taylor Dental, P.C. may periodically request to take photographs, slides, and/ or videos of your face, jaws and teeth. The photographs, slides, and or videos will be used as a record of your care, and may be used for educational and marketing purposes in lectures, demonstrations, and professional publications including our avenues of social media and website.

Please CHECK ONE of the following:

☐ **I consent to all photographs (full face included) and authorize East Taylor Dental to use my photos as described above.**

☐ **I consent to "teeth only" photographs and authorize East Taylor Dental to use my photos as described above.**

☐ **I consent to photographs for record of my care, but do not release any photos for marketing purposes.**

I further understand that if the photographs, slides, and/or videos are used in any publication, or as part of a demonstration, or on our website, reasonable attempts will be made to conceal my identity (i.e. no name or other identifying info will be given, full face photos excluded).

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the ETD- Informed Consent.

Print Patient Name: _____

Print Parent/Guardian Name (if under the age of 18): _____

Signature: _____

Date: _____

Killian J. Horner, DDS
Jennifer D. Ahn, DMD
2201 Taylor Rd.
Montgomery, AL 36117

Phone: 334-271-4600
Fax: 334-271-4709
Email: info@easttaylordental.com
Office Privacy Official: Andrea Horner

EAST TAYLOR DENTAL, PC
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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to maintain the privacy of protected health information, provide you with notice of our privacy practices, and to notify affected individuals following a breach of unsecured protected health information. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS:

The most common reason why we use or disclose your health information is for treatment, payment or health care operations.

Treatment: Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us.
Payment: Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney).
Health Care Operations: "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

We will ask for special written permission in the following situation: To transfer your records to other general dentists.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION:

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation/inspection of possible violations of health care laws, government programs, and compliance with civil right laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research approved by an institutional review board or privacy board;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking

government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;

- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- to assist in disaster relief efforts;
- to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA;
- disclosures to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Individuals Involved in Your Care of Payment for Your Care: We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

APPOINTMENT REMINDERS:

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will call, text, E-mail, and/or mail you an appointment reminder on a post card. We will also leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home, unless you tell us otherwise.

OTHER USES AND DISCLOSURES:

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." Your written authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of personal health information (PHI) for marketing, and for the sale of PHI. The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office privacy official named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

The law gives you many rights regarding your health information. You can/will:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) whom you want the limits to apply. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office privacy official at the address, fax or E-mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E -mail address. We will accommodate all reasonable requests. **However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.** If you want to ask for confidential communications, send a written request including the alternative means or location, and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request to the office privacy official at the address, fax or E-mail shown at the beginning of this Notice.
- ask to see or to get copies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request is readily producible. You will be charged in advance a reasonable cost-based fee for making paper and electronic copies of patient information, for mailing copies in paper and electronic format, and for preparing summaries and explanations of patient information. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have

one 30 day extension of the time for us to give you access or copies if we send you a written notice of the extension. If you want to review or get copies of your health information, send a written request to the office privacy official at the address, fax or E-mail shown at the beginning of this Notice.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office privacy official at the address, fax or E-mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office privacy official at the address, fax or E-mail shown at the beginning of this Notice.
- receive notifications of breaches of your unsecured protected health information as required by law. This office is not responsible for potential third party access to patient information sent and received via an unencrypted E-mail or E-mail address.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office privacy official at the address, fax or E-mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES:

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office privacy official at the address, fax or E-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION:

If you want more information about our privacy practices, call or visit the office privacy official at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of our Dental Notice of Privacy Practices.
I understand that I should ask our dental practice's Office privacy official if I have any questions about these policies and procedures. ****You May Refuse to Sign This Acknowledgment****

Print Patient Name: _____

Print Parent/Guardian Name (if under the age of 18): _____

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)** _____

Effective Date of Notice: January 1, 2015

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Dr. Jennifer D. Ahn, DMD
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Office Privacy Official: Andrea Horner

EAST TAYLOR DENTAL, PC
HIPAA CONSENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object, we are allowed to use our professional judgment in deciding whether to discuss your medical and payment information with your family member or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

Please CHECK ONE of the following:

☐ **You may communicate with the following individuals relating to my medical or payment information.**

_____

☐ **Please do not discuss my medical or payment information with the following individuals.**

_____

☐ **Please do not discuss my medical or payment information with anyone.**

Print Patient Name: _____

Print Parent/Guardian Name (if under the age of 18): _____

Signature: _____

Date: _____