NEW PATIENT REGISTRATION
SMILES...That Last a Lifetime

Patient Information

Date _____ ☐ Male ☐ Female

Patient's Name _____

Age_____ Birthdate_____

Address _____

City _____ State _____ Zip _____

Phone_____

Is the patient living with both parents: ☐ Y ☐ N

Mother's Name _____

DOB _____ SSN _____

Home #_____ Cell #_____

E-Mail _____

Father's Name _____

DOB _____ SSN _____

Home #_____ Cell #_____

E-Mail _____

Preferred Method of Contact:

☐ Text ☐ E-mail ☐ Cell Phone ☐ Home Phone

Dental Insurance

Primary Insurance

Policy Holder Name _____

Address _____ DOB _____

Insurance Company _____

Social Security # _____ ID # _____

Group # _____

Employer _____

Secondary Insurance

Policy Holder Name _____

Insurance Co. _____

Address _____

Social Security # _____ DOB _____

Group # _____ ID # _____

Employer_____

I certify that I (or my dependent) have insurance coverage and assign directly to KidZdent all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature _____ **Date** _____

Dental History

Has your child ever seen another dentist? ☐ Yes ☐ No

Name of dentist _____

Date of the last visit _____

Were Radiographs taken? _____

Has your child ever injured their head, mouth and/or teeth?

☐ Yes ☐ No Explain _____

Does/did your child take a bottle to bed at night? ☐ Yes ☐ No

Is your child having dental problems now? ☐ Yes ☐ No

Explain _____

Sleep & Breathing History

Does Your Child

- Have sleep, snoring, or breathing issues? _____
- Awaken at night or come to bed with you? _____
- Have allergies or ear infections? _____

Is your child a mouth breather? _____

Does/ Did your child have a finger or pacifier habit?_____

Was your child breast fed? _____

Are you concerned about your child's speech? _____

Please Choose ALL Referral Sources

☐ 1. Website
☐ 2. Google Search
☐ 3. Social Media
☐ 4. KidZdent Sign / Drive By
☐ 5. Parents were Patients
☐ 6. Insurance Company
☐ 7. Name of School _____
☐ 8. Community Event _____
☐ 9. Patient Name _____
☐ 10. Dentist Name _____
☐ 11. Pediatrician Name _____
☐ 12. Therapist (OMT/PT) _____

Medical History

Patient's Physician _____

Physician's Phone Number _____

Are all immunizations up to date _____

Date and reason for last examination by physician

_____

Has your child ever had a general anesthetic? _____

If yes, please explain _____

Is your child allergic to any Medications? ☐ Yes ☐ No

If yes, list all medications _____

Are there any other allergies? ☐ Yes ☐ No

If yes, please list _____

_____

Is your child taking medications now? ☐ Yes ☐ No

If yes, please list _____

Medical Conditions

Please check all conditions that apply:

Y	N		Y	N		Y	N	
☐	☐	Latex Allergy	☐	☐	Heart Ailments	☐	☐	Thyroid Disorders
☐	☐	ASD / Autism	☐	☐	Rheumatic Fever	☐	☐	Ulcer or Colitis
☐	☐	Extreme Nervousness or Apprehension	☐	☐	Epilepsy or Seizures	☐	☐	Malignancies or Leukemia
☐	☐	Developmentally Delayed	☐	☐	Heart Murmur	☐	☐	Chicken Pox
☐	☐	Cerebral Palsy	☐	☐	Sinus Ailments	☐	☐	Mononucleosis
☐	☐	Hyperactivity / ADHD	☐	☐	Tonsilitis	☐	☐	Hearing Ailments
☐	☐	Learning Disability	☐	☐	Tuberculosis	☐	☐	Eye disorders
☐	☐	Psychiatric Care / Emotional Ailments	☐	☐	Kidney Ailments	☐	☐	Physical Handicaps
☐	☐	Asthma or Other Respiratory Ailments	☐	☐	Diabetes	☐	☐	Excessive Bleeding
☐	☐	Liver Ailments, Jaundice, or Hepatitis	☐	☐	Aids / HIV+	☐	☐	Anemia or Blood Ailments

Other Medical Conditions _____

Social & Behavioral History

Interests _____ Favorite Toys _____

Sports Played _____ Pets _____

Special Experience_____ Favorite Video Game_____

Is there anything else that you think we should know about your child? _____

APPOINTMENT POLICY: PLEASE NOTIFY THIS OFFICE 24 HOURS PRIOR TO AN APPOINTMENT IF YOU MUST CANCEL IT. KIDZDENT WILL CHARGE *$50.00* FOR NO-SHOW APPOINTMENTS AND APPOINTMENTS CANCELED WITHOUT 24-HOUR NOTICE.

KidZdent follows Federal and State law by complying with HIPPA standards. Our Notice of Privacy Practices took effect on April 15, 2003 and is available to you at request.

I certify that I have read and understood the above. I understand that the information that I have given is correct to the best of my knowledge. I will not hold **KidZdent** or any member of the staff responsible for any errors or omissions I may have made in the completion of this form. I authorize the Doctor's and staff of **KidZdent** to perform the necessary dental services that they have explained me, including any Radiographs and Photos.

Signature of Parent/Guardian _____ **Date** _____

Parent/Legal Guardian Consent for Dental Treatment

Child's Name	*Date of Birth*
Child's Name	*Date of Birth*
Child's Name	*Date of Birth*
Child's Name	*Date of Birth*

Parent/Legal Guardian Contact	*Phone Number #1*	*Phone Number #2*

In the absence of a Parent/Legal Guardian: The following named caregiver(s) is (are) hereby authorized to consent for all dental treatment, for the above-named child(ren), which may be required during my absence. I agree to pay for all services provided to my child(ren) that the caregiver authorized.

Authorized Caregiver's Name	*Relationship to Patient*	*Home Phone #*	*Cell Phone #*
Authorized Caregiver's Name	*Relationship to Patient*	*Home Phone #*	*Cell Phone #*

This consent serves as permission for treatment by KidZdent for the above-named child(ren).
This authorization will remain in effect until I revoke this authorization in writing and submit it to KidZdent.

Signature of Agreement & Authorization

Parent/Legal Guardian (circle one)	*Date*
Parent/Legal Guardian (circle one)	*Date*

If circumstances permit and/or if KidZdent needs to contact me, please contact me at the following phone number: _____

***** NOTE: Consents are NOT required in emergency situations. *****

Billing Your Insurance

If your insurance plan is out of network, we may not be able to determine exactly how they will pay until after the claim has been submitted.

KidZdent is in -network with Delta Dental Premier, Aetna DMO (restrictions apply), and Cigna Total DPPO. All other insurance carriers are considered out of network with KidZdent.

Please know your insurance policy is a contract between you and your insurance company. We are not a party to that contract if we are out of network.

As a courtesy to you, our office will submit to your insurance, and once the claim payment has been received, we will send a statement if there is a balance due from you. This balance should be paid within 30 days of receipt to avoid any late fees. We accept Cash, Checks, and Credit/Debit Cards. We impose a surcharge on credit cards that is not greater than our cost. Our office invites you to pay with alternative methods to avoid the surcharge, by using your debit card, check, cash, Apple Pay, Google Pay, FSA, or HSA cards.

I, _____, understand I am responsible for paying any remaining balance after insurance has paid its allowable amount.

Signature of Parent/Guardian/Patient: _____

Date: _____

PHOTOGRAPHS AND VIDEOTAPE RELEASE AND AUTHORIZATION

I, _____, hereby consent to and authorize the use and reproduction by **KidZdent** (the "Practice") and its affiliates, including without limitation Dental Care Alliance, L.L.C. and its subsidiaries ("Affiliates"), or anyone authorized by any of them, of any and all photographs, electronic images or video footage of me taken by any of them, or that they have in their possession, provided either by me or by a third party (collectively, the "Images"), as well as any of the digital files, proofs, and negatives connected and associated with the Images, for educational, commercial, or any other purposes without compensation to me.

Such use shall include, but not be limited to, distributing the Images via print, visual and electronic media, specifically including any websites and social media sites such as YouTube and Facebook. I understand and agree that any Images authorized by me may also disclose my Protected Health Information ("PHI") related to my treatment, condition, procedure, surgery or other PHI associated with such Images, and I specifically authorize this disclosure. The Images, as well as any of the digital files, proofs, and negatives connected and associated with the Images, shall be the sole property of the Practice and its Affiliates. The Practice and its Affiliates also shall have the right to use my name in connection therewith if they so choose.

I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM or matter that may be used in conjunction therewith or to the eventual use that it might be applied.

I hereby release, discharge and agree to hold harmless the Practice and its Affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and name and the reproduction thereof as stated above, including any claim for payment in connection with the Images or distribution or publication thereof.

I understand that I have the right to refuse to sign this release and authorization and that it is strictly voluntary. If I do not sign this form, my dental health care and the payment for my dental health care will not be affected. I understand that this authorization will remain in effect until revoked by me in writing. I understand that I may revoke this authorization at any time in writing by delivering notice of revocation to the Practice, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. I understand that once the above information is disclosed, it may no longer be protected by privacy laws if such laws do not apply to the designated recipient, and it may be re-disclosed by the designated recipient. I understand that I may see and obtain a copy of the Images described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign.

☐ **Not for social media use**

IN WITNESS WHEREOF, I have duly executed the foregoing release and authorization on the date stated immediately below.

_____ _____

Signature of Patient / Legal Representative Date

_____ _____

Witness Date

Office Name: KidZdent Office City/State: Old Bridge, NJ

www.KidZdent.com
Pediatric Dentistry & Orthodontics
The Center for Preventive Dental Care.

To Whom It May Concern,

I hereby authorize the release of all dental X-rays to KidZdent. Please forward my child's x-rays as outlined below:

Child's Name: _____

Date of Birth: _____

Please send the records to **info@kidzdent.com**

Thank you for your prompt assistance.

Sincerely,

Parent/Guardian Name:

Date:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on the above date, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at 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 provide the new Notice at our practice location and on our website, and we will distribute it 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 use and disclose health information about you without authorization for the purposes of treatment, payment, and healthcare operations.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a doctor or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may share your health information with your health insurance plan so that it will pay for your services.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities; reviewing the competence or qualifications of healthcare professionals; evaluating practitioner and provider performance; and conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for the following purposes, 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 your written authorization, we will not use or disclose your health information for any reason that is not described in this Notice or otherwise permitted by applicable law.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of a family member, your personal representative or another person responsible for 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 absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment, and we will disclose only health information that is directly relevant to the person's involvement in your healthcare.

Marketing or Sale: We will not use your health information for marketing communications, nor disclose your health information in exchange for remuneration, without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

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 institutions or law enforcement officials having lawful custody the health information of an inmate or patient under certain circumstances.

Correspondence: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters), other correspondence, and missed appointment notifications.

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 readily produce the requested format. 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. You may also request access by sending us a letter to the address at the end of this Notice. If you prefer, we will prepare a summary or an explanation of your health information. We may charge you a reasonable cost-based fee for a copy or summary of your health information. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Accounting of Disclosures and Breach Notification: You have the right to receive a list (an "accounting") of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other disclosures (such as any you authorized us to make) during the 6 years prior to the date you ask for the list. 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. You have the right to be notified following a breach of your unsecured protected health information.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

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 by using the contact information listed at the end of this Notice. Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Substance Use Disorder Treatment Records: In the event we receive any of your substance use disorder ("SUD") treatment records from your SUD provider, we will not further disclose such SUD records without your express written consent or in response to a valid court order.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact our Privacy Official, 1549 Ringling Blvd. Suite 520, Sarasota, FL 34236, Ph #: (941) 955-3150.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your request to access or amend your health information, 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. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. 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.

AVISO DE PRÁCTICAS DE PRIVACIDAD

ESTE AVISO DESCRIBE CÓMO SE PUEDE UTILIZAR Y DIVULGAR SU INFORMACIÓN MÉDICA Y CÓMO PUEDE ACCEDER A ELLA. REVÍSELO CON DETENIMIENTO.
LA PRIVACIDAD DE SU INFORMACIÓN MÉDICA ES IMPORTANTE PARA NOSOTROS.

Nuestro deber legal

La legislación federal y estatal aplicable nos obliga a mantener la privacidad de su información médica protegida. También estamos obligados a entregarle este aviso sobre nuestras prácticas de privacidad, nuestros deberes legales y sus derechos en relación con su información médica protegida. Debemos seguir las prácticas de privacidad que se describen en este aviso mientras esté en vigor. El presente aviso entra en vigor en la fecha arriba indicada y seguirá vigente hasta que lo sustituyamos.

Nos reservamos el derecho a cambiar nuestras prácticas de privacidad y los términos de este aviso en cualquier momento, siempre que dichos cambios estén permitidos por la legislación aplicable. Nos reservamos el derecho de hacer efectivos los cambios en nuestras prácticas de privacidad y los nuevos términos de nuestro aviso para toda la información médica que conservamos, incluida la información médica que creemos o recibamos antes de realizar los cambios. Antes de realizar un cambio significativo en nuestras prácticas de privacidad, cambiaremos este aviso y proporcionaremos el nuevo aviso en nuestro consultorio y en nuestro sitio web, y lo distribuiremos a petición.

Puede solicitar una copia de nuestro aviso en cualquier momento. Si desea obtener más información sobre nuestras prácticas de privacidad o desea copias adicionales de este aviso, póngase en contacto con nosotros utilizando la información que figura al final de este aviso.

Usos y divulgaciones de la información médica

Utilizamos y divulgamos información médica sobre usted sin autorización para fines de tratamiento, pago y operaciones de asistencia médica.

Tratamiento: podemos utilizar o divulgar su información médica para su tratamiento. Por ejemplo, podemos divulgar su información médica a un médico u otro profesional de atención médica que lo esté tratando.
Pago: podemos utilizar y divulgar su información para obtener el pago de los servicios que le prestamos. Por ejemplo, podemos compartir su información médica con su seguro médico para que pague sus servicios.
Operaciones de atención médica: podemos utilizar y divulgar su información médica en relación con nuestras actividades de atención médica. Por ejemplo, las operaciones de atención médica incluyen actividades de evaluación y mejora de la calidad, la revisión de la competencia o las cualificaciones de los profesionales médicos, la evaluación del rendimiento de profesionales y proveedores, y la realización de programas de formación, acreditación, certificación, concesión de licencias o actividades de acreditación.

Su autorización: además de nuestro uso de la información médica para los fines que se indican a continuación, puede autorizarnos por escrito a utilizarla o a divulgarla a cualquier persona para cualquier fin. Si nos da una autorización, puede revocarla por escrito en cualquier momento. Su revocación no afectará ninguna utilización o divulgación permitida por su autorización mientras estaba en vigor. A menos que nos proporcione su autorización por escrito, no utilizaremos ni divulgaremos su información médica por ningún motivo que no se describa en este aviso o que no esté permitido por la legislación aplicable.

Personas implicadas en la atención: podemos utilizar o divulgar información médica para notificar o ayudar a notificar a un familiar, a su representante personal o a otra persona responsable de su cuidado, su localización, su estado general o su fallecimiento. Si está presente antes de utilizar o divulgar su información médica, le daremos la oportunidad de oponerse a dichos usos o divulgaciones. En caso de su ausencia o incapacidad, o en circunstancias de emergencia, divulgaremos información médica con base en una determinación que utilice nuestro criterio profesional y solo divulgaremos la información médica que sea directamente importante para la participación de la persona en su atención médica.

Comercialización o venta: no utilizaremos su información médica para comunicaciones de mercadeo, ni la divulgaremos a cambio de remuneración sin su autorización por escrito.

Exigido por ley: podemos utilizar o divulgar su información médica cuando nos lo exija la ley.

Salud pública y beneficio público: podremos utilizar o divulgar su información médica para denunciar abuso, negligencia o violencia doméstica; para notificar enfermedades, lesiones y estadísticas vitales; para comunicar determinada información a la Administración de Alimentos y Medicamentos (Food and Drug Administration, FDA); para alertar a alguien que pueda estar en riesgo de contraer o propagar una enfermedad; para actividades de supervisión médica; para determinados procedimientos judiciales y administrativos; para determinados fines policiales; para evitar una amenaza grave para la salud o la seguridad, y para cumplir con los programas de compensación a trabajadores o similares.

Seguridad nacional: podemos revelar a las autoridades militares la información médica del personal de las Fuerzas Armadas en determinadas circunstancias. Podemos revelar a funcionarios federales autorizados información médica necesaria para actividades legales de inteligencia, contrainteligencia y otras actividades de seguridad nacional. Podemos revelar a instituciones penitenciarias o a funcionarios encargados de hacer cumplir la ley que tengan la custodia legal la información médica de un recluso o paciente en determinadas circunstancias.

Correspondencia: podemos utilizar o divulgar su información médica para enviarle recordatorios de citas (como mensajes de voz, postales o cartas), otro tipo de correspondencia y notificaciones de citas a las que no haya asistido.

Derechos del paciente

Acceso: tiene derecho a ver u obtener copias de su información médica con excepciones limitadas. Puede solicitar que le proporcionemos copias en un formato distinto al de las fotocopias. Utilizaremos el formato que solicite, a menos que no podamos producir con facilidad el formato solicitado. Debe presentar una solicitud por escrito para obtener acceso a su información médica. Puede obtener un formulario para solicitar acceso utilizando la información de contacto que figura al final de este aviso. También puede solicitar acceso enviándonos una carta a la dirección que figura al final de este aviso. Si lo prefiere, le prepararemos un resumen o una explicación de su información médica. Podemos cobrarle una tarifa razonable basada en los costos por una copia o resumen de su información médica. Póngase en contacto con nosotros utilizando la información que figura al final de este aviso para obtener una explicación completa de nuestra estructura de tarifas.

Informe de las divulgaciones y notificación de infracciones: tiene derecho a recibir una lista (un "informe") de los casos en que nosotros o nuestros socios comerciales hayan divulgado su información médica para fines distintos del tratamiento, pago, operaciones de atención médica y otras divulgaciones determinadas (como las que usted nos haya autorizado a hacer) durante los 6 años anteriores a la fecha en que solicite la lista. Si solicita este informe más de una vez en un período de 12 meses, podemos cobrarle una tarifa razonable basada en los costos por responder a estas solicitudes adicionales. Tiene derecho a recibir una notificación en caso de que se produzca una violación de su información médica protegida no garantizada.

Restricción: tiene derecho a solicitar que impongamos restricciones adicionales a nuestro uso o divulgación de su información médica. En la mayoría de los casos no estamos obligados a aceptar estas restricciones adicionales, pero si lo hacemos, nos atendremos a nuestro acuerdo (excepto en determinadas circunstancias, como una emergencia, para actividades de salud pública, o cuando la divulgación sea requerida por la ley). Debemos cumplir con una solicitud para restringir la divulgación de información médica protegida a un plan de salud con el fin de llevar a cabo el pago o las operaciones de atención médica (según se define en la Ley de Portabilidad y Responsabilidad del Seguro Médico [Health Insurance Portability and Accountability Act, HIPAA]) si la información médica protegida se refiere únicamente a un artículo o servicio de atención médica por el que se nos haya pagado de nuestro bolsillo en su totalidad.

Comunicación alternativa: tiene derecho a solicitar que nos comuniquemos con usted en relación con su información médica por medios o lugares alternativos. Debe presentar su solicitud por escrito utilizando la información de contacto que figura al final de este aviso. Su solicitud debe especificar el medio o lugar alternativo y proporcionar una explicación satisfactoria sobre cómo se gestionarán los pagos en el medio o lugar alternativo que solicita.

Enmienda: tiene derecho a solicitar que modifiquemos su información médica. Su solicitud debe hacerse por escrito y debe explicar por qué se debe modificar la información. Podemos denegar su solicitud en determinadas circunstancias.

Notificación electrónica: puede recibir una copia en papel de este aviso si lo solicita, aunque haya aceptado recibirlo por vía electrónica en nuestro sitio web o por correo electrónico (e-mail).

Registros de tratamiento por trastornos por uso de sustancias (SUD)

En el caso de que recibamos cualquiera de sus registros de tratamiento por trastornos por uso de sustancias ("SUD") de su proveedor de SUD, no revelaremos más dichos registros de SUD sin su consentimiento expreso por escrito o en respuesta a una orden judicial válida.

Preguntas y reclamaciones

Si desea obtener más información sobre nuestras prácticas de privacidad o tiene alguna pregunta o duda, póngase en contacto con nuestro responsable de privacidad, 1549 Ringling Blvd. Suite 520, Sarasota, FL 34236, n.º de teléfono: (941) 955-3150.

Si le preocupa que podamos haber violado sus derechos de privacidad o no está de acuerdo con una decisión que hayamos tomado sobre su solicitud de acceso o modificación de su información médica, de restricción del uso o divulgación de su información médica, o de que nos comuniquemos con usted por medios alternativos o en lugares alternativos, puede presentar una queja utilizando la información de contacto que figura al final de este aviso. También puede presentar una queja por escrito al Departamento de Salud y Servicios Humanos de los Estados Unidos. Si lo solicita, le facilitaremos la dirección para presentar su queja ante el Departamento de Salud y Servicios Humanos de los Estados Unidos. Apoyamos su derecho a la privacidad de su información médica. No tomaremos ningún tipo de represalia si decide presentar una queja ante nosotros o ante el Departamento de Salud y Servicios Humanos de los Estados Unidos.

Acknowledgement of Receipt of Notice of Privacy Practices; Consents to Communications

TO BE COMPLETED BY THE PATIENT OR THE PATIENT'S PERSONAL REPRESENTATIVE (E.G., PATIENT'S PARENT OR LEGAL GUARDIAN)

Last Name _____ First Name _____ Middle Name _____

Date of Birth _____ Home Phone _____ Mobile Phone _____

Email Address _____ Patient Name (if completed by Personal Representative) _____

	Yes	No
I acknowledge receipt of this dental office's ("Practice") Notice of Privacy Practices.	☐	☐
I consent to receive recall appointment reminder information at the mailing address on file with the Practice.	☐	☐
I consent and agree to receive calls and text messages from or on behalf of the Practice and its affiliates at the home and/or mobile phone numbers provided above. These calls and text messages may include (but are not limited to) those concerning my health care, my account and insurance, and the Practice's services and may include marketing content. These calls and texts may be placed using automatic dialing or pre-recorded/artificial voice technology, and standard message or data rates may apply. I understand that my consent is voluntary and is not a required condition for receiving care from the Practice. I understand that I can unsubscribe at any time by calling the Practice or replying "STOP" to a text message from the Practice or its applicable affiliate.	☐	☐
I consent to receive voice messages from the Practice and its affiliates containing health information at the home and/or mobile phone numbers provided above.	☐	☐
I consent to receive email communications from or on behalf of the Practice and its affiliates at the email address provided above. I understand that these communications may include (but are not limited to) operational notices about my account and insurance and are part of my relationship with the Practice. I also understand that these communications may include promotional communications, including, but not limited to, newsletters, information about new services or suggested screenings, special offers, surveys and other news and information that the Practice thinks will be of interest to me. I understand that I may opt out of receiving promotional emails at any time by following the unsubscribe instructions provided therein. I understand that if I opt out of receiving promotional communications from the Practice, I may still receive transactional communications, including emails about my account or relationship with the Practice.	☐	☐

I permit the Practice to share appointment, billing, and general dental/health information with the following individual(s) who are involved in my (or, if I am the patient's personal representative, the patient's) care (*e.g.*, a family member, friend, caregiver):

_____

I understand that I may revoke any of the above consents at any time by so advising the Practice in writing. My revocation of any consent will not affect my (or, if I am the patient's personal representative, the patient's) ability to receive services from Practice.

Signature of Patient / Personal Representative _____ *If Personal Representative, relationship to Patient* _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Patient / Personal Representative refused to sign form ☐ Other: _____

Signature of Office Manager _____ Date _____