Hymas Family Dental

Date _____

**Whom may we thank for referring you?** _____

First Name _____ Last Name _____ Middle Initial _____

Patient Is ☐ Policy Holder ☐ Responsible Party Preferred Name _____

## Responsible Party ( if someone other than the patient )

First Name _____ Last Name _____ Middle Initial _____

Address _____ Address 2 _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Ext _____ Cell _____

Birth Date _____ Soc Sec _____ Drivers Lic _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

## Patient Information

Address _____ Address 2 _____

City _____ State / Zip _____

Home Phone _____ Work Phone _____ Cell _____

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

Birth Date _____ Age _____ Soc Sec _____ Drivers Lic _____

E-mail _____ I would like appointment reminders via E-mail ☐ Text ☐

### Section 2

Employment Status ☐ Full Time ☐ Part Time ☐ Retired

Student Status ☐ Full Time ☐ Part Time

Medicaid ID _____ Pref. Dentist _____

Employer ID _____ Pref. Pharmacy _____

Carrier ID _____

### Section 3

Emergency Contact _____

Emergency Phone # _____

Relationship _____

OK to phone @ work? _____

Employer _____

48 Notice _____

## Primary Insurance Information

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

Insured Soc. Sec _____ Insured Birth Date _____

Employer _____ Ins. Company _____

Address _____ Address _____

Address 2 _____ Address 2 _____

City, State, Zip _____ City, State, Zip _____

Rem. Benefits _____ Rem. Deduct _____

## Secondary Insurance Information

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

Insured Soc. Sec _____ Insured Birth Date _____

Employer _____ Ins. Company _____

Address _____ Address _____

Address 2 _____ Address 2 _____

City, State, Zip _____ City, State, Zip _____

Rem. Benefits _____ Rem. Deduct _____

***ASSIGNMENT AND RELEASE***

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Relationship _____ Date _____

Hymas Family Dental

Patient Name _____

Birthdate _____

*Teeth Whitening* *Replacement of missing teeth* *Cosmetic evaluation*
*Straight teeth* *White fillings* *Home care* *Breath control*

## DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ Phone # _____ City/State _____

Date of last dental visit _____ Date of last dental X-Rays _____

Date of last dental cleaning _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? ☐ Electric Toothbrush ☐ Manual Toothbrush ☐ Soft ☐ Medium ☐ Hard
☐ Toothpick ☐ Fluoride Rinse ☐ Other_____

Have you received any formal oral hygiene instruction? Y / N How long ago? _____

Do you like your smile? Y / N Rate your smile from 1 - 10 _____

How do you feel about the appearance of your teeth? _____

What do you wish could be changed? _____

Are you interested in straightening your teeth (orthodontic treatment)? Y / N Have you had braces before? Y / N

Please circle YES or NO to indicate if you have had or currently have any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Gag easily | Y N | Discomfort with HOT foods/liquids | Y N | Pain in face, cheeks, jaw joint | Y N |
| Avoid brushing because of pain | Y N | Clench or Grind your teeth | Y N | Chew on only one side of the mouth | Y N |
| Notice slow-healing sores in the mouth | Y N | Temporamandibular jaw disorder | Y N | Gums feel swollen or tender | Y N |
| Your Jaw makes noise OR gets stuck | Y N | Take fluoride supplements | Y N | Discomfort with sweet or sour food | Y N |
| Earaches or pain in front of your ear | Y N | Difficutly chewing | Y N | Discomfort when chewing | Y N |
| Habitually chew gum | Y N | Gums bleed when flossing | Y N | Had trauma to the jaw | Y N |
| Gums bleed easily | Y N | Discomfort with COLD food or liquid | Y N | | |

**If you could change your smile, what would you like to change?** *(please circle)*

*The color of my teeth* *Close spaces or restore worn and broke teeth*
*The shape of my teeth* *The position or alignment of my teeth*
*Other* _____

**I'm interested in** *(please circle)*

*Teeth Whitening* *Replacement of missing teeth* *Cosmetic evaluation*
*Straight teeth* *White fillings* *Breath control*

| | |
|---|---|
| A serious injury to the mouth or head | Y N |
| Food collection between teeth | Y N |
| Oral Surgery (Extractions) | Y N |
| Endodontic Treatment (Root Canals) | Y N |
| Periodontal Treatment (Gums- Deep Cleaning) | Y N |

Please describe, including the cause _____

Please indicate location _____

If yes, please indicate:

Osseous Surgery Date _____

Tissue Gingival Grafts Date _____

Tissue Management (Scaling, Curetage) Date _____

| | |
|---|---|
| Do you feel nervous about having dental treatment? | Y N |
| Have you ever had an upsetting dental experience? | Y N |
| *Do you have any other concerns about your mouth?* | Y N |

If yes to any of the above, please describe _____

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# MEDICAL HISTORY

Hymas Family Dental

Patient Name _____

Birthdate _____

Physician's Name _____ Date of Last Visit _____

Address _____ City _____ State _____ Zip Code _____

Have you been under the care of a medical doctor during the past two years? **Y N** If yes, please explain. _____

_____

Do you take, or have you taken, Phe-n-Fen or Redux? **Y N**

Have you ever taken Fosamax, Boniva., Acton el or any other medications containing bisphosphonates? **Y N**

**Do you use controlled substances? Y N**

Please circle yes or no to indicate if you have had any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | Y N | Diabetes | Y N | Hepatitis B or C | Y N | Rheumatic Fever | Y N |
| Alzheimer's Disease | Y N | Drug Addiction | Y N | Herpes | Y N | Rheumatism | Y N |
| Anaphylaxis | Y N | Easily Winded | Y N | High Blood Pressure | Y N | Scarlet Fever | Y N |
| Anemia | Y N | Emphysema | Y N | High Cholesterol | Y N | Shingles | Y N |
| Angina | Y N | Epilepsy or Seizures | Y N | Hives or Rash | Y N | Sickle Cell Disease | Y N |
| Arthritis/Gout | Y N | Excessive Bleeding | Y N | Hypoglycemia | Y N | Sinus Trouble | Y N |
| Artificial Heart Valve | Y N | Excessive Thirst | Y N | Irregular Heartbeat | Y N | Spina Bifida | Y N |
| Artificial Joint | Y N | Fainting Spells/Dizziness | Y N | Kidney Problems | Y N | Stomach/Intestinal Disease | Y N |
| Asthma | Y N | Frequent Cough | Y N | Leukemia | Y N | Stroke | Y N |
| Blood Disease | Y N | Frequent Diarrhea | Y N | Liver Disease | Y N | Swelling of Limbs | Y N |
| Blood Transfusion | Y N | Frequent Headaches | Y N | Low Blood Pressure | Y N | Thyroid Disease | Y N |
| Breathing Problems | Y N | Genital Herpes | Y N | Lung Disease | Y N | Tonsillitis | Y N |
| Bruise Easily | Y N | Glaucoma | Y N | Mitral Valve Prolapse | Y N | Tuberculosis | Y N |
| Cancer | Y N | Hay Fever | Y N | Osteoporosis | Y N | Tumors or Growths | Y N |
| Chemotherapy | Y N | Heart Attack/Failure | Y N | Pain in Jaw Joints | Y N | Ulcers | Y N |
| Chest Pains | Y N | Heart Murmur | Y N | Parathyroid Disease | Y N | Venereal Disease | Y N |
| Cold Sores/Fever Blisters | Y N | Heart Pacemaker | Y N | Psychiatric Care | Y N | Yellow Jaundice | Y N |
| Congenital Heart Disorder | Y N | Heart Trouble/Disease | Y N | Radiation Treatments | Y N | | |
| Convulsions | Y N | Hemophilia | Y N | Recent Weight Loss | Y N | | |
| Cortisone Medicine | Y N | Hepatitis A | Y N | Renal Dialysis | Y N | | |

**Allergies** [ ] NONE [ ] Amoxicillin [ ] Aspirin [ ] Barbiturates [ ] Codeine [ ] Epinephrine [ ] Erythromycin [ ] Keflex
[ ] Iodine [ ] Latex [ ] Lortab [ ] Morphine [ ] Penicillin [ ] Sulfa [ ] Tetracycline [ ] Other _____

List medications currently taking (name and dosage) _____

_____

Do you have or have you had any disease, condition or problem not listed above? Y N

If yes, please explain _____

**Do you need to take any antibiotics (pre-medicate) before any dental appointment?** Y N

Have you been in the hospital or had a serious illness within the past five years? Y N

If yes, Please explain _____

Women: Are you pregnant? Y N Due date_____ Are you nursing? Y N Do you take Birth Control Pills? Y N

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.

**Patient / Parent / Guardian Signature X** _____ Date _____

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Hymas Family Dental

Patient Name _____

Birthdate _____

## *CONSENT FOR SERVICES, APPOINTMENT AND PAYMENT POLICIES*

Hymas Family Dental is happy to take care of your dental needs. Please help us by following our appointment and payment policies.

***Broken or cancelled appointments***

Please remember that once you have made an appointment this time has been reserved just for you. **We require at least 2 business days notice if a change in schedule is necessary. There will be a $50 fee charged for any appointments cancelled with less than 48 hours notice. This will apply to any failed (no show) appointments also.** This will allow us to schedule another patient in need of treatment and waiting for an appointment at that time. We appreciate your courtesy in this matter.

I acknowledge and understand the cancellation policy ***X*** _____ Date _____
Signature of patient or responsible person

***Appointment Reminder & Communication Consent***

**Important Note:** We use cell phone numbers and email addresses to remind patients of future appointments.I consent to Chet A. Hymas, DMD and Hymas Family Dental Employees contacting me electronically by the email address and/or cell phone below for the purpose of receiving appointment reminders, notification that I need to make an appointment, office information and events, dental records, survey regarding dental visit, or reminders of uncompleted treatment. I understand that during the transmission of these messages, the information contained at one point or another may pass through a public network and onto a personal electronic device and as such the transmission may not be secure. However, the practice will not transmit any personal or confidential information about your health, procedures or account status without your permission. (Please note that email messages from our office are encrypted if the message contains any personal health information). I agree to inform the practice if my email address or cell phone number changes. I understand and acknowledge that I can cancel this consent at any time.

I acknowledge and understand the Communication Consent policy ***X*** _____ Date _____
Signature of patient or responsible person

If you would NOT like to be contacted by email or text messages, you may Opt Out of one or both by initialing below.* If you change your mind at any time, you may call us at (509) 994-3824.

_____ I elect to Opt Out of email

_____ I elect to Opt Out of text messaging

*If you choose to Opt Out of electronic communication, what is the best way to contact you?

Home Phone _____ Work Phone _____ Mobile Phone_____

Do you give permission to leave messages on these devices, such as appointment times, pre-treatment estimate amounts, pre-medication reminders (if applicable), etc. Yes _____ No _____

***Insurance and Financial Agreement***

Our practice is in-network for most dental insurance carriers, and we are a PPO provider. Please provide your insurance card on your first visit, and let us know of changes in coverage or carriers on subsequent visits. As a courtesy, our office files all necessary paperwork with your insurance company; our friendly staff will be happy to help you maximize your dental benefits. Many dental insurance policies have exclusions and limitations that can affect your out-of-pocket cost.

At the time of service, you will need to pay the expected estimated insurance deductible and any estimated amount that we expect your insurance will not cover. Remember that many procedures may not be fully covered; in those instances, you are responsible for the remaining amount. However, please remember that your dental insurance policy is a contract between you, your employer and the insurance company. This Practice is not a party to that contract and therefore cannot guarantee that any or all services will be covered. Please keep in mind that you are responsible for the total amount should your insurance benefits result in less coverage than anticipated. Before proceeding with treatment, we will provide a written estimate of fees. Althoughwe try to get accurate information about insurance benefits and coverage before treatment, we cannot guarantee what the insurance company will pay, if anything, until the claim is submitted and the insurance company actually pays the claim. It is not unusual for insurance companies to give us erroneous information about coverage or benefits. This is important because you are responsible for all treatment charged, whether or not your insurance company provides any benefits. Also, some companies take care of claims promptly while others delay payment for several months. After 60 days from the treatment day if payment is not received from your insurance, the payment will be due in full from you and the insurance company will be reimbursing you. Please understand that we cannot accept responsibility for collecting your insurance claim or for negotiating disputed claims between you and your insurance company.

**We want you to feel comfortable and confident in all aspects of our Practice. Remember we do not treat according to your insurance. We treat you as an individual and care about your dental health. We are dedicated to providing the best treatment available to our patients.**



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***Insurance claims***
If we file an insurance claim for you, at the time of treatment you will need to pay the estimated insurance deductible and any estimated amount that we expect insurance will not cover. We try to get accurate information about insurance benefits and coverage before treatment, but we cannot be sure what the insurance company will pay, if anything, until the claim is submitted and the insurance company actually pays on the claim. It is not unusual for insurance companies to give us erroneous information about coverage or benefits. This is important because you are responsible for all treatment charged, whether or not your insurance company provides any benefits.

***Payment is due at the time of treatment***
Payment for treatment is due in full at the time of treatment, unless you have made other payment arrangements with us. Please read the next section for an explanation of payment arrangements. However, payment is due at the time of service for the Initial Emergency or Limited appointments.

***Payment in Full*** Payment in full at time of service. Loyalty Discounts may be available for cash pay patients who do not have insurance.
***Insurance Co-payment*** Patient who has insurance pays their estimated portion - due at the time of service.
***Care Credit*** (Good credit standing required)
Free interest up to 6 months upon credit approval
Payment plans up to 36 months
Prepayments can be made anytime without penalty
Fast, confidential service by phone, 1-800-365-8295, or online at their secure website, www.carecredit.com

***Estimates***
Treatment plans are subject to modification depending on any unforeseen or undiagnosed circumstances that may arise during the course of treatment. The listed fees and insurance reimbursement are **ESTIMATES** only; the final charges will be based on the actual treatment rendered. All professional services are the responsibility of the patient and are charged directly to their account. Your portion is due at the time of service and a finance charge of 1.0% per month will be added to all accounts 90 days past due. The fees quoted are guaranteed for 90 days from date on treatment plan

***Returned checks***
Please take every precaution to avoid returned checks. It is time consuming for our staff to deal with returned checks and this takes away from the more important job of providing dental services. For this reason, we charge $30.00 for any check that is returned to us without payment. Also, if you have given us a bad check in the past, we will not accept a personal check from you in the future as payment for dental services.

***Interest on late payments***
Please pay your charges on time. We rely on prompt payment from our patients and their insurance companies. We will charge your account interest at the rate of 1.5% per month (18% annually) for charges not paid within 30 days. We recommend patients understand their insurance benefits and monitor their plans for prompt payment.

***Collection costs***
We will charge your account for our collection costs if we refer your account to an outside agency or attorney for collection. These costs include the collection agency's commission and, if an account is collected after the start of a collection lawsuit, reasonable attorneys' fees and expenses and court costs. For a referred account that is collected prior to the start of a collection lawsuit, we will add 43% to the principal amount due so that the office will be left with the full principal amount after deducting the collection agency's commission from the amount collected.

***Regarding minors in the office***
Minors MUST ALWAYS be accompanied by an adult. The adult accompanying a minor will be responsible for payment of services. If parent is giving authorization for a Caregiver, the permission form needs to be completed prior to their visit.

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*I have read, understand and agree to the above policies and financial agreement. Any questions and concerns were answered fully to my satisfaction. I understand that I am responsible for all fees and/or balances due and agree to pay them in a timely manner in order to avoid any additional charges. I, the undersigned (patient or legally responsible party) hereby assume all financial responsibilities for treatment rendered. Furthermore, I authorize release of any information relating to my insurance claims and the assignment of any and all dental benefits paid directly to Hymas Family Dental, DMD., PLLC. I understand that I am responsible for all costs of dental treatment and any additional costs incurred in collecting this account, including interests, court cost and attorney fees, which may be added to my balance. I agree to the above policies and charges.*

**X**_____ Date _____
*Signature of patient or responsible person*

Name of patient _____

Name of person responsible for patient charges, if different _____


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## Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Patient name _____ Birthdate: / /

I have read and been offered a hard copy or an electronic copy of the HIPAA Notice of Privacy Practices for Hymas Family Dental. I understand that I am entitled to receive a hard copy of the Notice if I ask for it, even if I have already agreed to receive only an electronic copy.

***X*** _____ Date signed: _____

*Signature of patient or responsible person*

Relationship to patient – Please Circle One **SELF** **PARENT** **GUARDIAN** **LEGAL REPRESENTATIVE**

***If applicable:***

Patient's Guardian or Representative's name _____ Phone_____

Representative's relationship to patient: _____

Representative's address:

_____

## Permission To Discuss Treatment Or Billing Information

I give permission to discuss my treatment and or billing information with:

Name_____ Relationship to patient _____

Name_____ Relationship to patient _____

Name_____ Relationship to patient _____

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Hymas
Family Dental

## Patient Photo Release

I hereby authorize Hymas Family Dental and/or any of their assignees to take photographs, slides, and/or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, social media, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name (First Name Only) or other identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs.

**Please initial:**

_____ I give permission for my first name, face, and teeth to be used in any of the above stated situations.

**Exceptions:**

_____ I do not wish to have my first name shown, or released.
_____ I do not wish to have my face shown.
_____ I only agree to have my teeth shown without any identifying features.
_____ I do not wish to have my photos used at all.

Name _____

***X*** _____ Date signed: _____

*Signature of patient or responsible person*

Relationship to patient – Please Circle One **SELF** **PARENT** **GUARDIAN** **LEGAL REPRESENTATIVE**

***If applicable:***
Patient's Guardian or Representative's name: _____ Phone: _____

Representative's relationship to patient: _____

Representative's address:
_____

*Our initial notice was effective July 1, 2012.*

**HIPAA 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.
(PATIENT COPY: PLEASE RETAIN FOR YOUR RECORDS; Reviewed January 2019

**Who Will Follow This Notice**
This notice describes the privacy practices of Hymas Family Dental, located in Spokane Valley, Washington. These privacy practices apply to our dental practice and to our staff, including our dentists, hygienists and other health care professionals, and employees working at our offices. Some of our dentists are independent contractors and are not employees or agents.

**Our Pledge Regarding Health Information**
We understand that medical information about you and your health is personal. We are committed to protecting your health information. We create a record of the care and services you receive at our offices. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated or kept by our dentists, hygienists and other staff. This notice will tell you about the ways we may use and disclose your health information. We also describe your rights and certain obligations we have concerning the use and disclosure of your health information.

We are required by law to:
Make sure that health information that identifies you is kept private;
Give you this notice of our legal duties and privacy practices with respect to health information about you; and follow the terms of this notice that is currently in effect, as we may change it from time to time.

**How We May Use and Disclose Your Health Information**
The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment:** We may use your health information to provide you with dental treatment or services. We may disclose health information about you to dentists, dental assistants, hygienists, other dental office personnel or other health care providers who are involved in your treatment or care. For example, your dentist may need to disclose some of your health information to order tests or lab work to be performed at an outside laboratory or other outside health care provider, or your dentist may need to disclose your health information to people outside the office who may be involved in your dental or health care after you leave the dental office, such as family members, or clergy.

**For Payment:** We may use and disclose health information about your treatment and services to bill and collect from you, your insurance company or a third party payer. For example, we may need to give your dental/health insurance plan information so that it will pay us or reimburse you for dental services. We may also tell your health insurance plan about a treatment you are going to receive to determine whether your plan will cover it.

**For Health Care Operations:** We may use and disclose your health information for office operations. These uses and disclosures are necessary to run our dental office and make sure that all of our patients receive quality care. For example, we may use your health information to review our treatment and services and to evaluate the performance of our staff in caring for you. Some of these reviews may be conducted by independent dentists who are members of our staff, but are not employees of the office. We may also combine health information about many of our patients to decide what additional services we should offer and what services are not needed. We may also disclose information to dentists, hygienists, dental assistants and other office personnel for review and learning purposes. We may also combine the health information we have with health information from other dental practices to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

**Appointment Reminders:** We may use and disclose health information to contact you as a reminder that you have an appointment for treatment at our office.

**Treatment Alternatives:** We may use and disclose health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Benefits and Services:** We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care:** We may disclose your health information to a member of your family, your friend or another individual who is directly involved in your care and the disclosure is necessary for your welfare. The practice will limit the health information disclosed to the family member, friend or other individual to health-related signs and symptoms and to information designed to help you deal with your condition or treatment, including setting and changing appointments, receiving instructions for post-visit care or picking up treatment-related items. We may also disclose a limited amount of your health information to locate you or to locate or notify your family member or friend. We may also give information to someone who helps pay for your care. We will not make these disclosures to your friends and family without your authorization.

**Research.** Under certain circumstances, we may use and disclose health information about you for research purposes. We generally will obtain your written authorization to use your medical information for research purposes. There may be limited circumstances when access to your information for research purposes may be allowed without your specific consent.

**Business Associates:** There are some services that we provide through contracts with business associates. For example, we use an outside copy service if needed to make copies of your x-rays. When these services are contracted, we may disclose your health care information to our business associate so that the associate can perform the job we have asked the associate to do. To protect your health information, we require the business associate to safeguard the privacy of your information.

**As Required by Law:** We will disclose health information about you when required to do so by federal, state or local law.

**To Avoid a Serious Threat to Health or Safety:** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

**Military and Veterans:** If you are a member of the armed forces, we may release health information about you as required by military command authorities.

**Workers' Compensation:** We may release your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. Your written authorization to this release is required, however, if you do not consent to a release of information, your workers' compensation benefits may be denied and you will be responsible for the costs of your dental care.

**Public Health Risks:** We may disclose your health information for public health activities. These activities generally include the following:
prevention or control of disease, injury or disability,
reporting births and deaths,
reporting abuse or neglect of children, elders and dependent adults, reporting reactions to medications or problems with products,
notifying people of recalls of products they may be using or
notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**Health Oversight Activities:** We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

**Law Enforcement:** We may release health information if asked to do so by a law enforcement official: In response to a court order, subpoena, warrant, summons or similar process, To identify or locate a suspect, fugitive, material witness or missing person, About the victim of a crime if, under certain limited circumstances, we are unable to obtain the persons' agreement, About a death we believe may be the result of criminal conduct, About criminal conduct at the hospital and In emergency circumstances to report a crime, the location of the crime or victims or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors:** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of the hospital to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities:** We may release health information about you to authorized federal officials for intelligence, counter intelligence, and other national security activities authorized by law.

**Protective Services for the President and Others:** We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

**Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official if the release would be necessary for the institution to provide you with health care, to protect your health and safety and the health and safety of others or for the safety and security of the correctional institution.

**Permission from you:** Other uses and disclosures of health information not covered in the above categories will be made only with your permission. You may give permission with a written consent or authorization. If you provide us permission to use or disclose health information about you, you may revoke that permission at any time orally or in writing. If you revoke your permission, we will no longer use or disclose health information about you to the extent your permission is needed for the use or disclosure. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provide to you.

**Your Health Information Rights**
You have the following rights concerning health information we maintain about you:

**Right to Inspect and Copy your Health Information:** You have the right to inspect and copy your health information and to receive a written summary or explanation of your health information if you make a request in writing by completing our records authorization form and you will be provided the information and copy of records within 72 hours after the administrative fee and authorization form are completed. If you want to inspect, copy or receive this information, please contact the privacy officer listed at the end of this notice to obtain and complete the required form. If you request a copy of your health information, we will charge you a fee for the costs of copying, mailing, compiling and/or printing your request or of preparing a written summary or explanation, as well as for administrative feesz that will cover labor costs. We may deny your request in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the office will review your request and denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Receive your Health Information in Electronic Form:** If you make a request on or after February 17, 2010, for an electronic copy of health information that we maintain in electronic form, we will provide the information in electronic form to you or directly to a third party of your choice. For providing an electronic copy of your health information, we will charge you our labor costs in responding to your request.

**Right to Ask for Changes in Health Information:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to change or add to the information. You have the right to ask for a change or addition for as long as the information is kept by the office. You should contact the privacy officer listed at the end of this notice to get the form you will need to ask for a change or addition. You must give us a reason for your request. We may deny your request for a change or addition to your health information if it is not in writing or does not include an appropriate reason to support the request. In addition, we may deny your request if you ask us to change or add to information that: we did not create, unless the person or entity that created the information is no longer available to make the change or addition, is not part of the health information kept by the office, is not part of the information which you would be permitted to inspect and copy or is already accurate and complete.

**Right to an Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of the disclosures we made of your health information except for: disclosures made to carry out treatment, payment or health care operations, disclosures to you, disclosures made pursuant to your authorizations, disclosures to persons involved in your care and certain other special disclosures described in federal regulations. To ask for this list of disclosures, you should contact the privacy officer listed at the end of this notice to get the form you will need to fill out for this purpose. Your request must state a time period, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. Because any restrictions of your information may hinder the quality of care provided by our facility, according to the law, we reserve the right to deny your request. We do not have to agree to the restrictions that you request, but if we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you should contact the privacy officer at the address or number listed at the end of this notice to get the form you will need to fill out for this purpose. In your request, you must tell us:
what information you want to limit, whether you want to limit our use, disclosure or both and to whom you want the limits to apply (for example, your spouse, your children, your parents or other involved in your care). To be binding on us, any agreement to comply with special restrictions must be in writing signed by the privacy officer for our office.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about your health information in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the privacy officer listed at the end of this notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact the privacy officer listed at the end of this notice or ask any of our staff members.

**Right to be Notified if Breach of Security:** You have the right to be notified if there is a breach of security with respect to your protected health information. In the event of such a breach, we will notify you directly in writing or, if your contact information is out of date, we will take steps to notify you by other means, such as a posting to our web site or notices in print or broadcast media.

**Changes to this Notice**
We reserve the right to change this notice and the revised or changed notice will be effective for health information we already have about you as well as any information we receive in the future. The current notice will be posted in our dental offices and will include the effective date.

**Complaints**
If you believe your privacy rights have been violated, you may file a complaint with our dental office or with the Secretary of the Department of Health and Human Services. To file a complaint, contact the privacy officer listed at the end of this notice or ask any of our staff members. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

**Privacy Officer and Contact Information**
Hymas Family Dental
Mailing address: 420 N Evergreen Rd Ste 400, Spokane Valley, Washington 99216, (509)922-1360

Hymas Family Dental