PREETHA THOMAS, D.M.D.
(817) 912 1218
THOMASDMD@ENCLAVEDENTAL.COM
500 WEST SOUTHLAKE BOULEVARD
SUITE #130
SOUTHLAKE, TX 76092

Welcome to Enclave Dental.
Please fill the following information so that we can best serve you. Thank you:

PATIENT:

LAST NAME:_____ FIRST:_____ INITIAL:_____
How do you wish to be addressed?
DOB _____
Marital Status: ☐Single ☐Married ☐Divorced
Address _____
City_____ State_____ Zip _____
Telephone (Home) _____ _____ _____ (Work) _____ _____ _____ (Mobile)_____ _____ _____
Email: _____
Employer: _____ Occupation:_____
SSN: _____.
Dental Insurance Co. Group _____
Is patient covered by another dental insurance? ☐Yes ☐No
Insurance Co:_____

How did you hear about our practice? _____
Whom may we thank for your referral? _____

RESPONSIBLE PARTY OR PARENT INFORMATION

LAST NAME:_____ FIRST:_____ INITIAL:_____
DOB: _____
Address _____
City_____ State_____ Zip _____
Telephone (Home) _____ _____ _____ (Work) _____ _____ _____ (Mobile)_____ _____ _____
Email: _____
Employer: _____ Occupation:_____
SSN: _____.
Dental Insurance Co. Group _____

EMERGENCY CONTACT INFORMATION:

LAST NAME:_____ FIRST:_____ INITIAL:_____
DOB: _____
Address _____
City_____ State_____ Zip _____
Telephone (Home) _____ _____ _____ (Work) _____ _____ _____ (Mobile)_____ _____ _____
Email: _____

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TERMS OF AGREEMENT AND UNDERSTANDING WITH ENCLAVE DENTAL:

I understand that I must read the following section and sign that I have read it before any treatment will be provided. I understand that **Enclave Dental** is not making any promise that everything will be perfect and all the work done is going to be permanent. I realize that my natural teeth can decay, chip, crack, break or give way, despite the best efforts of the doctor and all associated people involved in the care of my teeth. The results cannot be guaranteed or predicted with certainty. I understand that the doctor has her/his own limitation despite the best effort made by her/him and may not be able to provide what I desire or what I think I deserve.
I understand that any warranties on dental materials or procedures are good only if I keep up with my regular scheduling for cleaning , scaling and root planning (if needed) and follow up office visits as advised.
I have read the above and I agree to consider these concepts in my expectations.

Signature:_____ Date:_____

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT AT ENCLAVE DENTAL:

Your Dental Health is very important to us. We also want you to be comfortable knowing that nothing is more crucial to us that protecting you and your health. We are here to help you afford your dental treatment. When the type of treatment has been decided upon, time will be appointed to complete the treatment. All financial arrangements will be made with you during that time. We are required to obtain consent from you for all the following. Please read and sign the bottom of the page. Please ask us if you have any questions.

1. **Use of the diagnostic tools**: I hereby authorize the Dentist and staff at Enclave Dental to take x-rays, study models, photographs, and any other diagnostic aids that may be appropriate to make a thorough diagnosis of my dental needs. If you are signing for a minor or you are the care giver please write the patients name here: _____

2. **Agreeing to treat**: Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

3. **Disclosure of Health history**: I have disclosed my complete health history, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

4. **Local Anesthetic**: I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

5. **Saving my life**: I authorize the doctor and any other qualified assistants or medical professionals to administer any needed medication that may be required as a life-saving measure and to perform any compulsory life-saving procedures.

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6. **Personal information**: I give consent to the doctor's or designated staff's use and disclosures of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed.

7. **Insurance**: I agree to be responsible for payment of all services rendered on my behalf or my dependents and I understand that payment is due at time of service. I also understand that Enclave Dental is considered out of network with my insurance company and is not a party of contract between me and my insurance company. I am also aware that my co-payment for services rendered is due on the date of service. Enclave Dental will assist me in filing the dental claim with my insurance company but I will still be responsible for my own insurance reimbursement.

8. **Returned Checks**: If my check is returned by the bank I understand that there is a fee of $40 that will be attached to my account.

9. **Past Due Accounts**: I understand that if my account becomes past due, necessary steps will be taken to collect the debt. If this office has to refer to an agency to collect the debt, I agree to pay all the collection costs, which may be incurred. If a lawyer is engaged for any such activity I agree to pay all the lawyer fees plus the court costs that were incurred because of my dealings with Enclave Dental.

10. **Payment methods**: I understand that I can make payments by cash, credit card or debit card on the day of the treatment. On extensive treatment I can secure a third party financing. I am aware that Enclave Dental offers Care Credit as an option and I can get a financial plan with low monthly rate with no interest for 6 months. I can chose to put the entire amount on Care Credit and make payments to the lending institute. I understand that all financial arrangements and insurance questions will be discussed with me in advance.

11. **Co-signature**: I understand that if another person signs this, the co-signature remains in effect until canceled in writing. If written signature is received, it becomes effective with any subsequent changes.

Patient's Signature_____**Date**_____

Witness _____

Responsible Party's Signature_____**Relationship** _____

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Time 2:26 PM | Enclave Dental | Date 5/6/2016

Eaglesoft Medical History(Copy)

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

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major	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? Including herbal supplements.	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	
Do you use tobacco?	Yes No	

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

Do you use controlled substances?	Yes No	If yes
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						

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

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Dental History

What is the reason for today's visit?		omment	
Are you in pain?	Yes No		
If so, how long and where?	Yes No	If yes	
Do you require a pre-medication before dental	Yes No		
Date of last dental visit? Xrays?	Yes No	If yes	
Previous dentist?	Yes No	If yes	
How often do you brush and floss your teeth?	Yes No	If yes	
Do you use any dental aids?	Yes No	If yes	
Have you ever had an allergic reaction to local or general anesthetic or nitrous oxide?	Yes No	If yes	
Have you had any trouble with previous dental care?	Yes No	If yes	

Please mark yes or no to all of the following:

Bad Breath	Yes No
Burning Sensation of the Tongue	Yes No
Chew on One Side of Mouth	Yes No
Dry Mouth	Yes No
Food Collection Between Teeth	Yes No
Clench or Grind Teeth	Yes No
Growths or Sore Spots	Yes No
Bleeding, Swollen or Tender Gums	Yes No
Head, Neck, or Jaw Pain	Yes No
Lip or Cheek Biting	Yes No
Mouth Breathing	Yes No
Clicking or Popping of Jaw	Yes No
Sensitive Teeth	Yes No
Orthodontic Treatment	Yes No
Periodontal Treatment	Yes No
Loose Teeth	Yes No
Whitening Treatments	Yes No
Root Canal Treatments	Yes No

Would you like to change anything about your smile?	Yes No	If yes	
Do you have any other concerns or quesitons that have not been listed?	Yes No	If yes	

Signature of Patient, Parent or Guardian:

X

Date:_____

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Cancellation and No-Show Policy

Our office hours are by appointment only and we do value your time. Appointment time is reserved for you alone. Where appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please be sure that you will be able to keep it.

Like many offices, our office will call to confirm your appointment. We will call 48 hours in advance to confirm your appointment and also call 24 hours prior to the appointment if we have not heard back from you. Please return our call to confirm your appointment and make a note of any dental appointments you have scheduled with us. If you cannot make an appointment as scheduled, please notify the office 48 hours in advance. There will be a charge of **$50 per 30 minutes** of scheduled time for a no call/no show/cancellation with less than 24 hours notice for your appointment.

We are one of the few providers that take care of newborn babies and mothers who are struggling with feeding issues. Our open appointment time slots are precious for parents who are in need. We understand the importance of educating parents on the after care and we reserve over an hour of time for those families. This is to ensure there is enough time for parents and the baby to relax and recover after the procedure as well. Please be courteous to others and make every effort to give us a 24 hour notice if you decide you need to cancel this type of appointment and so as to not receive any charges from our office.

Our aim is to have every patient/ family that walks into our office to leave knowing that they received the best care possible. We strive to keep your comfort, your peace and your well-being ahead of everything else. Please help us to serve you better.

If you have any questions about our appointment cancellation and no-show policy, please feel free to call us/ ask us. By signing below you are agreeing to our office policy.

Patient/ Guardian name: _____

Signature: _____ **Date:** _____

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Dental Photography Release and Consent

I hereby allow **Enclave Dental** and its representatives the irrevocable and unrestricted right to reproduce and display photographs of me in print, on the **Enclave Dental** website, or any other lawful purpose for advertising. I release Enclave Dental and its employees and legal representatives from any and all claims, actions and liability relating to its use of said photographs. I understand that any pictures taken will be a property of Enclave Dental and will be used for advertising or educational purpose as deemed necessary. By signing below I agree to the above.

Date: _____ Signature: _____

For Minors:

If the above signee is a person under the age of 21, parent or guardian should sign below:

I _____ the parent or guardian, hereby consent to the foregoing.

Signature _____

Date _____

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Acknowledgement of Receipt of
HIPAA Notice of Privacy Practices ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of ***HIPAA Notice of Privacy Practices*** from **Enclave Dental.**

I understand that Enclave Dental office may periodically change the ***HIPAA Notice of Privacy Practices*** and that I am entitled to receive a copy of the office's revised ***HIPAA Notice of Privacy Practices*** upon request.

I understand that, if I have questions about the office and its ***HIPAA Notice of Privacy Practices***, I may contact Dr. Preetha Thomas DMD.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that **Enclave Dental** will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **Enclave Dental's** privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask the staff or the doctor noted above, for assistance.

_____ Patient Signature	_____ Date
_____ Signature of Personal Representative	_____ Print Name of Personal Representative
	_____ Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

Enclave Dental made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its ***HIPAA Notice of Privacy Practices***. In spite of these efforts, we were unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	By	Patient ID

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Notice of Privacy Practices

Enclave Dental

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.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Enclave Dental ("Dental Offices") "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Enclave Dental's Privacy Official at:

thomasdmd@enclavedental.com

Phone#: 817 912 1218

500 west Southlake Blvd, Suite 130, Southlake, TX, 76092

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on **April 20th 2015**

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health

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information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse

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reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

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Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a

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written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. 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 paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We

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will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is April 20th 2015.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.