Dental Horizons
Guiding Generations to Healthy Smiles

Adult Patient Registration

Today's Date_____

Name: _____ Marital Status_____
Last *First* *MI*

Home Phone # _____ Cell Phone # _____ Work Phone #_____

Address: _____ Date of Birth: _____
Apt # *City* *State* *Zip*

SS#_____ Email: _____ Age_____ Male □ Female □

Employer_____
Name *Address*

Please provide a copy, screen shot, or digital photo of your Dental Insurance information.
Or fill out the information below:

Dental Insurance _____
Company *Group #* *Address*

Name of Insurance Policy Holder: _____
Last *First* *MI*

Insurance Policy holder's information:

Date of Birth _____ Age_____ Social Security #: _____

Employer_____
Name *Address*

Dental Insurance (Secondary) _____
Company *Group #* *Address*

How were you referred to this office? □ Friend or Family (Name) _____
□Community Event □ Yellow Pages □ Facebook □ Walk in □ Mailer
□ Internet site _____ □ Referred by Dr. _____ □Other _____

How will today's services be taken care of? □ Cash □ Check □ Credit Card (MC/Visa)

I certify that the above information is complete and accurate and the information on the Medical History, Dental History, and Sleep Screen Questionnaires.

_____
Signature of Patient, Parent or Guardian *Date*

All forms can be submitted electronically via fax, e-mail or digital photo

Dental History

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Name: _____ Date: _____

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of previous dentist and how long were you a patient there? _____

Date of most recent dental exam: _____ Date of most recent dental x-rays: _____

I routinely see a dentist every:

☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

What is your immediate dental concern? _____

Personal Dental History, Check all that apply

- ☐ I had trouble getting numb or reactions to local anesthetic
- ☐ I had other unfavorable dental experience or complications from past dental treatment (beyond anesthetic)
- ☐ I had orthodontic treatment

Smile Characteristics, Check all that apply

- ☐ I would like to change the appearance of my teeth
- ☐ I have whitened my teeth in the past
- ☐ I have been disappointed with the appearance of previous dental work

Bite and Jaw Joint, Check all that apply

- ☐ I have pain or discomfort in the jaw joint
- ☐ I have noticed wear on my teeth
- ☐ I have noticed crowding or spacing in my teeth
- ☐ I have a history or currently chew ice, bite nails, or have other habits that affect the teeth
- ☐ I clench my teeth during the daytime or at nighttime
- ☐ I have worn or currently wear a nightguard

Tooth Structure, Check all that apply

- ☐ I have had cavities within the last three years
- ☐ I have a dry mouth with limited saliva
- ☐ I have holes, grooves, notches, or spaces in the teeth where food gets caught

Gum and Bone, Check all that apply

- ☐ My gums bleed when I am brushing or flossing
- ☐ I have a history of periodontal diagnosis and/or treatment
- ☐ I am concerned about bad breath
- ☐ I have noticed my gums receding
- ☐ I have loose teeth without any injury

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Financial Policy

Thank you for choosing **Dental Horizons**. Our primary mission is to deliver the highest quality and comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by clarifying financial responsibilities in advance. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment.

Agreement

Dental Horizons fees reflect our commitment to the quality of treatment and materials our patients deserve. We require payment in full at the time of service. If you have dental insurance, we require payment of your estimated portion for services provided that day. For your convenience, we accept cash, personal checks, Visa, MasterCard, Discover, and Care Credit.

Billing Statement: Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued and is past due after 30 days from statement date. Balances older than 30 days will accrue interest at the rate of 1.5% per month or 18.00% per year.

Credit History: If written financial arrangements are made, you give Dental Horizons permission to check your credit history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency or credit bureau.

Missed appointment fee: Patients who do not show up for an appointment or cancel with less than 24 hours' notice may be charged a $65.00 fee. This fee must be paid before a new appointment is scheduled.

Retuned check charge: Dental Horizons charges a $35.00 fee for returned checks with non-sufficient funds.

Past due accounts: If your account becomes past due, we may take necessary steps to collect this debt. If a collection agency or attorney must be used, you agree to pay all the collection costs, attorney's fees, and court costs associated with the collection.

Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We cannot compromise on your care, but we can do our best to help you get the benefits you deserve. Our office is obligated to provide you with the treatment you need, but your insurance carrier is only obligated to pay for what your policy calls for. You are the responsible party for payment of services provided whether your insurance company pays or not.

As a courtesy to our patients, we will be happy to file the claim for your dental benefits from your dental insurance. However, if we do not receive payment from your insurance carrier within 45 days, you will be responsible for payment of your treatment fees and collection of your benefits from your insurance carrier. Ultimately, it is the patient's responsibility to keep up with all their insurance benefits and any changes. We cannot and do not guarantee payments from insurance companies and patients are expected to pay their estimated percentages and deductibles at the time their treatment is rendered.

Minors

The parent(s) or guardians accompanying a minor are responsible for the payment. Minors must be accompanied by a parent or legal guardian to receive treatment.

We are committed to providing excellent dental treatment to all our patients. By signing this agreement, you agree to all the terms and conditions explained above. Please let us know if you have any questions.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

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Cancelation Policy

Dental Horizons is committed to providing exceptional care for our patients.

We realize emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, advance notification allows us to fulfill other patients scheduling needs and keeps our office operating at its most efficient level. Please keep in mind that the doctor, assistants, hygienists, and front office staff all have time scheduled to help take care of your dental health.

1. Please provide our office with 24-hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice may be responsible for a $65 missed appointment charge. This charge must be paid on or before the next scheduled appointment.
2. After missing two appointments without notice, you may be placed on a same day scheduling policy. All future scheduled appointments may be cancelled and going forward, you will not be able to schedule any appointments in advance unless they are paid in full at the time of scheduling.
3. If appointments are missed or cancelled on a regular basis, it could affect the status of your overall oral health.
4. Should you arrive more than 15 minutes late to your appointment, your treatment may need to be modified or rescheduled.

Thank you for your cooperation. It is our belief that this policy will help us better serve each of our patients fairly and respectfully.

_____

Patient, Parent, or Guardian Signature Date

_____

Patient Name (Please Print)

Dental Horizons
600 S. Airport Rd., Suite 200-A, Longmont, CO 80503
303.776.3320 (Office) 303.485.9962 (Fax)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are properly kept confidential. HIPAA gives you, the patient, significant rights to understand and control how your health information is used.

HIPAA provides penalties for covered entities, including our Practice, that misuse "protected health information" (PHI). PHI 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 PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies takes effect on 10/10/13, and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

You may request a copy of our current Notice of Privacy Practices at any time. For more information about our practices, or for additional copies, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office, or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends, and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your care. If you are present, prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death, or in emergency circumstances, if deemed appropriate based upon our professional judgment, we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to obtain prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

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

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we may disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities. Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a sale of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI 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. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We will notify you of a breach of your unsecured PHI, as required by HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. 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 the additional requests. You have the right to request such an accounting in an electronic format.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency circumstances.

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

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

Electronic Notice: If you receive this Notice of Privacy Practices on our website or by e-mail, you are entitled to receive a copy in written form.

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI. 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.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer: Dr. Andrew Kelson

Address: 600 S. Airport Rd., Suite 200-A, Longmont, CO 80503

Telephone: 303.776.3320

Fax: 303.485.9962

Email: dakelson@dental-horizons.com

NOTICE OF MATERIAL CHANGES TO OUR PRIVACY PRACTICES POLICY

EFFECTIVE: OCTOBER 10, 2013

BACKGROUND

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) gives individuals the right to be informed of their healthcare providers' privacy practices and the right to understand and control how their health information is used. Healthcare providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices.

Our Practice has made material changes to our privacy practices, consistent with legal changes to HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). We will be providing all of our patients with our revised and updated Notice of Privacy Practices, and requesting a signed acknowledgment of receipt from each patient.

SUMMARY OF MATERIAL CHANGES TO OUR PRIVACY PRACTICES:

- We have added a statement to our Privacy Practices acknowledging that we may not use or disclose your protected health information for marketing purposes, including disclosures that constitute sales, without your authorization.
- We will be issuing new Patient Release of Records Authorization forms that allow patients to choose whether to allow or limit the Practice from disclosing their protected health information in certain ways, to include opting out of fundraising communications.
- If the Practice maintains a patient's psychotherapy notes, they will not be released unless you the patient signs an authorization or if otherwise required by law.
- Patients have the right to restrict the Practice from disclosing certain protected health information to health plan providers if the patient personally pays for their service in full.
- We have revised our internal privacy breach reporting practices to comply with 2013 changes in the HIPAA and HITECH privacy rules, and patients have a right to receive a notification of breaches of unsecured protected health information.
- Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose any genetic information to insurance providers or others for underwriting purposes.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer: Dr. Andrew Kelson

Address: 600 S. Airport Rd., Suite 200-A, Longmont, CO 80503

Telephone: 303.776.3320

Fax: 303.485.9962

Email: dakelson@dental-horizons.com

Medical History

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Name:_____ Date: _____

Do you have any allergies?

☐ None ☐ Allergies ☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Hay Fever
☐ Penicillin ☐ Sulfa ☐ Latex ☐ Other: _____

Indicate which of the following you have had or have at present.

Y N	Acid Reflux	Y N	Congenital Heart Def	Y N	HIV / AIDS	Y N	Sinus Problems
Y N	Annemia	Y N	Currently Pregnant	Y N	Kidney Disease	Y N	Sleep Apnea
Y N	Anxiety	Y N	Diabetes	Y N	Liver Disease	Y N	STI (Transmitted Inf)
Y N	Arthritis	Y N	Dizziness/Fainting	Y N	Low Blood Pressure	Y N	Stomach Problems
Y N	Artificial Bones	Y N	Drug Use	Y N	Nervous Disorders	Y N	Stroke
Y N	Artificial Joints	Y N	Excessive Bleeding	Y N	Osteoporosis	Y N	Thyroid Disorder
Y N	Artificial Valve	Y N	Frequent Headaches	Y N	Pacemaker	Y N	Tobacco Use
Y N	Asthma	Y N	Head Injuries	Y N	Psychiatric Disorder	Y N	Tuberculosis
Y N	Auto-immune Disorder	Y N	Heart Disease	Y N	Radiation Treatment	Y N	Tumors
Y N	Bacterial Endocarditis	Y N	Heart Murmur	Y N	Respiratory Issues	Y N	Ulcers
Y N	Blood Disease	Y N	Heart Surgery	Y N	Rheumatic Fever	Y N	Venereal Disease
Y N	Cancer	Y N	Hepatitis	Y N	Rheumatism	Y N	Other- explain below
Y N	Chest Pain	Y N	High Blood Pressure	Y N	Seizures		

Y N	Ever been hospitalized in the last 3 years	Y N	Presently being treated for any other illnesses
Y N	Taking medication for weight control (IE: fen-phen)	Y N	Females: taking birth control pills
Y N	Taking medication for osteoporosis (IE: Fosamax)		

If any condition selected above needs further clarification, please explain below: (We will review these verbally)

_____

_____

Do you take antibiotic premedication for your dental visits? YES / NO If yes, please explain.

_____

List all medications, supplements, and/or vitamins taken within the last two years:

_____

_____

_____

How would you rate your overall general health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of physician, their specialty, and date of most recent exam: _____

Describe any current medical treatment, impending surgery, or other treatments that may possibly affect your dental treatment:

_____

_____

☐ By checking this box, I acknowledge that the above information is correct, and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

Dental Horizons
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Sleep Screening Questionnaires

Today's Date_____

Name_____ **DOB**_____ Age_____

Height_____ **Weight**_____ **BMI**_____ BMI = (weight X 703)/(Height Inches X Height Inches)

STOP-BANG

			Yes	No
1.	Snore	Do you snore loudly? (Louder than talking or loud enough to be heard behind a closed door?	☐	☐
2.	Tired	Do you often feel tired, fatigued, or sleepy during daytime?	☐	☐
3.	Obstruction	Has anyone observed you stop breathing during your sleep?	☐	☐
4.	Pressure	Do you have or are you being treated for high blood pressure?	☐	☐
5.	BMI	Is your body mass index greater than 28?	☐	☐
6.	Age	Are you 50 years old or older?	☐	☐
7.	Neck	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches?	☐	☐
8.	Gender	Are you a male?	☐	☐

ESS: Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = never doze **1** = slight chance of dozing **2** = moderate chance of dozing **3** = high chance of dozing

	Situation	Chance of Dozing
1.	Sitting and reading	_____
2.	Watching TV	_____
3.	Sitting inactive in a public place (e.g. a theatre or a meeting)	_____
4.	As a passenger in a car for an hour without a break	_____
5.	Lying down to rest in the afternoon when circumstances permit	_____
6.	Sitting and talking to someone	_____
7.	Sitting quietly in a lunch without alcohol	_____
8.	In a car while stopped for a few minutes in traffic	_____
	Total out of 24	_____

1 -10 - Normal 10 - 16 - Excessively Sleepy 16 - 24 - Abnormally Sleepy

	YES	NO		Yes	No
Do you clench and grind your teeth at night?	☐	☐	Are you currently being treated for OSA?	☐	☐
Do you suffer from waking headaches?	☐	☐	Have you ever had a sleep test administered?	☐	☐
Do you ever wake up choking or gasping?	☐	☐	If YES – when was your sleep test?	_____	
Do you have blocked nasal passages?	☐	☐	Do you currently use a CPAP or Sleep Appliance?	☐	☐
Are you aware of a family history of OSA?	☐	☐	Are you happy with your CPAP or Sleep Appliance?	☐	☐
How often do you use the restroom at night?	_____		If NO – Why? _____		

_____
Patient Signature

Questionnaires adapted from www.EpworthSleepinessScale.com and Chung F, et. al Anesthesiology 2008; 108(5):812-821.

600 S. Airport Road, Suite 200-A, Longmont, CO 80503 ◦ dental-horizons.com ◦ 303.776.3320

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303.776.3320 (Office) 303.485.9962 (Fax)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Dental Horizon's Notice of Privacy Practices, which has an effective date of 10/10/2013, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____

Signature of Patient or Patient's Representative Date

_____

Print Name

_____

Relationship to Patient (If not signed by the Patient)