

Email:Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: <div>LastFirstMiddle</div>			Home Phone: <i>Include area code</i> ( )		Business/Cell Phone: <i>Include area code</i> ( )				
Address: <div>Mailing address</div>			City:		State: Zip:				
Occupation:			Height:		Weight:				
			Date of Birth:		Sex: M F				
SS# or Patient ID:		Emergency Contact:		Relationship:		Home Phone: <i>Include area code</i> ( )		Cell Phone: <i>Include area code</i> ( )	
If you are completing this form for another person, what is your relationship to that person?									
Your Name				Relationship					
<b>Do you have any of the following diseases or problems:</b>				<i>(Check DK if you Don't Know the answer to the the question)</i>				<b>Yes No DK</b>	
Active Tuberculosis.....								<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Persistent cough greater than a 3 week duration.....								<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Cough that produces blood.....								<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Been exposed to anyone with tuberculosis.....								<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.</b>									

Dental Information

For the following questions, please mark (X) your responses to the following questions.

<div>Yes No DK</div> <div>Do your gums bleed when you brush or floss?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Are your teeth sensitive to cold, hot, sweets or pressure?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Is your mouth dry?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Have you had any periodontal (gum) treatments?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Have you ever had orthodontic (braces) treatment?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Have you had any problems associated with previous dental treatment?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Is your home water supply fluoridated?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Do you drink bottled or filtered water?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY</div> <div>Are you currently experiencing dental pain or discomfort?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>	<div>Yes No DK</div> <div>Do you have earaches or neck pains?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Do you have any clicking, popping or discomfort in the jaw?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Do you brux or grind your teeth?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Do you have sores or ulcers in your mouth?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Do you wear dentures or partials?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Do you participate in active recreational activities?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Have you ever had a serious injury to your head or mouth?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Date of your last dental exam:</div> <div>What was done at that time?</div> <div>Date of last dental x-rays:</div>
What is the reason for your dental visit today?	
How do you feel about your smile?	

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<div>Yes No DK</div> <div>Are you now under the care of a physician?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Physician Name:Phone: <i>Include area code</i> ( )</div> <div>Address/City/State/Zip:</div> <div>Are you in good health?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>Has there been any change in your general health within the past year?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>If yes, what condition is being treated?</div> <div>Date of last physical exam:</div>	<div>Yes No DK</div> <div>Have you had a serious illness, operation or been hospitalized in the past 5 years?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>If yes, what was the illness or problem?</div> <div>Are you taking or have you recently taken any prescription or over the counter medicine(s)?.....<input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div> <div>If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:</div> <div></div> <div></div> <div></div> <div></div>
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Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)		Yes No DK	
Do you wear contact lenses?.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Date: ..... If yes, have you had any complications? .....			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Date Treatment began: .....			
<b>Allergies.</b> Are you allergic to or have you had a reaction to: To all <b>yes</b> responses, specify type of reaction.		Yes No DK	
Local anesthetics .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Aspirin .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Penicillin or other antibiotics .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Barbiturates, sedatives, or sleeping pills .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Sulfa drugs .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Codeine or other narcotics .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.</b>			
Yes No DK		Yes No DK	
Artificial (prosthetic) heart valve.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Previous infective endocarditis .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Damaged valves in transplanted heart .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Repaired (completely) in last 6 months.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Repaired CHD with residual defects .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.			
Yes No DK		Yes No DK	
Cardiovascular disease .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Angina .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Arteriosclerosis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Congestive heart failure.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Damaged heart valves .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Heart attack .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Heart murmur.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Low blood pressure .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
High blood pressure.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Other congenital heart defects.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Mitral valve prolapse.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Pacemaker.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Rheumatic fever.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Rheumatic heart disease.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Abnormal bleeding .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Anemia .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Blood transfusion.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
If yes, date:.....			
Hemophilia .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
AIDS or HIV infection.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Arthritis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Autoimmune disease.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Rheumatoid arthritis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Systemic lupus erythematosus.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Asthma.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Bronchitis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Emphysema.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Sinus trouble .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Tuberculosis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Cancer/Chemotherapy/ Radiation Treatment.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Chest pain upon exertion.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Chronic pain .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Diabetes Type I or II.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Eating disorder .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Malnutrition .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Gastrointestinal disease.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
G.E. Reflux/persistent heartburn .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Ulcers .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Thyroid problems .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Stroke.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Glaucoma .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Hepatitis, jaundice or liver disease.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Epilepsy .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Fainting spells or seizures .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Neurological disorders .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
If yes, specify:.....			
Sleep disorder .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Do you snore?.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Mental health disorders .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Specify:.....			
Recurrent Infections .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Type of infection: .....			
Kidney problems.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Night sweats .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Osteoporosis .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Persistent swollen glands in neck .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Severe headaches/ migraines .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Severe or rapid weight loss ....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Sexually transmitted disease..		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Excessive urination .....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.....			
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Name of physician or dentist making recommendation:		Phone: Include area code (    )	
Do you have any disease, condition, or problem not listed above that you think I should know about?.....			
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Please explain:			

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:	Date:
Signature of Dentist:	Date:

FOR COMPLETION BY DENTIST

Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please fill in the following information completely. If you have dental insurance, please provide a copy of your insurance card so that we can assist in filing your insurance claims.

Whom may we thank for referring you to our office? \_\_\_\_\_

**Financial Responsibility Information:**

Date: _____	SS#: _____		
Name: _____	Date of Birth: _____		
<i>Last</i>	<i>First</i>	<i>Middle Initial</i>	
Address: _____		City: _____	State: _____ Zip: _____
Home Phone: _____		Cell Phone: _____	Business Phone: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Email address: _____			
Employer: _____		Employer Address: _____	Occupation: _____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
Spouse's Name: _____		Birthdate: _____	SS#: _____ Occupation: _____
Spouse's Employer: _____		Spouse's Employer Address: _____	Phone: _____

**Dental Insurance Information:**

Insurance Company: _____		Phone: _____	
insurance Company Address: _____		City: _____	State: _____ Zip: _____
Employer: _____		Group #: _____	
Subscriber (Employee)Name: _____		ID#: _____	
SS#: _____		DOB: _____	
Address: _____		City: _____	State: _____ Zip: _____
Home phone: _____		Work Phone: _____	Cell Phone: _____

**Secondary Insurance Information: (Please complete only if you have secondary insurance coverage.)**

Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Insurance Company: _____		Phone: _____	
Insurance Company Address: _____		City: _____	State: _____ Zip: _____
Employer: _____		Group #: _____	
Subscriber (Employee)Name: _____		ID#: _____	
SS#: _____		DOB: _____	
Address: _____		City: _____	State: _____ Zip: _____
Home phone: _____		Work Phone: _____	Cell Phone: _____

**Assignment and Release: (Please read and sign)**

I certify that I, and/or my dependent(s) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Kevin M. Lacour all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. The above-named Dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

\_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_  
Date



WALTON DENTAL CARE  
COMMITTED TO EXCELLENCE, COMMITTED TO YOU

Kevin M. Lacour, D.D.S.  
Larry J. Miller, D.M.D.  
Stuart C. Knight, D.M.D.  
Family Dentistry  
www.waltondentalcare.com

862 Michael Etchison Road  
Monroe, GA 30655  
office: 770.267.2301  
fax: 770.267.8981

Welcome to our office! We are pleased to have you as a patient and look forward to caring for your dental health. We sincerely hope that the quality of your treatment will exceed your expectations. We do appreciate your time in completing the paperwork. It is important for us to know about your medical and dental histories to set up your personal records in our office, and we would like you to know what to expect of us in regard to office policies. We will be happy to answer any questions you may have. Thank you for your help.

1. Our goal is to see you promptly at your scheduled time. Please inform us as soon as possible in the event that you will need to change an appointment.
2. Payment is due when services are rendered (this includes any insurance deductible and/or co-insurances). We accept cash, checks, Visa, Mastercard, and Discover. In regard to minors: the parent requesting services for a minor child is financially responsible for those services provided.
3. For patients with dental insurance: We will be happy to assist you in filing your insurance claim, although you are ultimately responsible for your bill. We will file your insurance form for you after you have supplied us with a copy of your insurance card and the required information. This form must be signed to allow us to release the necessary information and allow the insurance company to remit payments to our office. Any co-insurance and/or deductibles are due at the time services are rendered.
4. **FEMALE PATIENTS:** Before each dental visit, please inform us if you are pregnant or may possibly be pregnant before x-rays are taken or anesthesia (including nitrous oxide or "gas") is administered.
5. **Medicare does not cover most procedures performed in this office.** Please see the "advance Medicare Directive" published by the American dental Association posted in the office – it offers more information on this subject. We will be happy to provide a copy of this information.
6. We have provided you with a copy of our "Notice of Privacy Practices". Please sign the "Consent for Use and Disclosure of Health Information" and "Acknowledgement of Receipt of Notice of Privacy Practices" and return it to the Front Desk along with the rest of your paperwork.

I have read and understand these Office Policies. I acknowledge that any questions I had in reference to the above have been answered to my satisfaction. **I, the undersigned (Patient or Legally Responsible Party), authorize treatment to be rendered and assume full financial responsibility. I acknowledge that all accounts over sixty (60) days old will be charged a service fee of 1.5% per month (18% annually) on the unpaid balance. Any collection and/or attorney fees incurred to collect this account will be borne by the account.**

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Patient Name (please print)

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Signature of Patient/Guardian

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Date



**Acknowledgement of Receipt of Notice of Privacy Practices**  
**Walton Dental Care**

\* You May Refuse to Sign This Acknowledgment\*

**I have received a copy of this office's Notice of Privacy Practices.**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

***For Office Use Only***

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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## **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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 07/01/2019, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

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

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### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment

activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

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

**Appointment Reminders.** We may 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 message or email.

**Disclosure to Business Associates.** We may disclose your health information to our third-party service providers ("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.

**Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

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

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:

- o Prevent or control disease, injury or disability;
- o Report child abuse or neglect; o Report reactions to medications or problems with products or devices; o Notify a person of a recall, repair, or replacement of products or devices; o Notify a person who may have been exposed to a disease or condition; or o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**National Security.** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI 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 instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI 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 disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.



## **Other Uses and Disclosures of PHI**

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

## **Your Health Information Rights**

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

**Amendment.** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach.** You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

## **Questions and Complaints**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Official: Kristy Claville

Telephone: 770-267-2301

Address: 862 Michael Etchison Rd Monroe, GA 30655 Email:  
info@waltondentalcare.com

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