Dr. S.R. Muecke D.D.S
Dr. D.L. Leever D.D.S.
Dr. L.O. Sims D.D.S
Dr. W.B. Zinney D.D.S

Aesthetic Dento-Facial Associates

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name: Married---- single---- child-------

Social Security# Birthdate__________________________

Phone (Home)____________(Work)_________(Cell)-----------------

Address:____

Street Apt#

____

City State Zip code

EMPLOYMENT INFORMATION

Employer Name________________________________ Occupation______________________

Address: ____

Street City Zip Code

INSURANCE INFORMATION

patient? Primary name of insured ______________ Ins Carrier ______________ Is insured a

Last First MI

Insured Birth Date_______________ Id No------------------- Grp#___________________

Insured Address____

City State Zip Code

Patient's relationship to insured: self---- spouse---- child---- other----

CONSENT FOR SERVICES

I understand payment is due in full at the time of treatment unless prior arrangements are made. I authorize the dental staff to perform the necessary dental services for my treatment and/or diagnosis.

Signature of patient or parent of minor: ________________ Date:______________________

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Protectingyourconfidentialhealthinformationisimportanttous

Abuse or Nqlect
We will notify government authorities ifwe believe a patient is dte victim of abuse, neglect or domestic violence. We will make this disclosure only when we arc compelled by our ethical judgment, when we believe we Ille specifically required or authorized by law or with the patient's agreement.

Public Health and Nadonal Security
We may be required to disclose to Federal officials or militacy authorities heal.th infwmation neces&acy to complete an investigation related to public health or national security. Health infonna l ion oould be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of ll drug treatment or medical device.

For Law Enfon:ement
As pennitted or required by State of Federal law, we may disclose YOW' health information to a law enforcement official for certain law enforcement pwposes, including, under certain limited circumstances, ifyou are a victim of a crime or in order to report a crime.

Family, Friends and Caregtven
We may share your health information with th05C you tell us will be helping you V lith your home hygiene, treatment, medications, or payment. We will be mre to aak your pennissioo first. In the case of an emergency, where you are able to tell us what you want we will use our very best judgment when sharing your health infonnation only when it will be important to those participating in providing your care.

Authorization tu Use or Disclose Health Information
Other than i& stated above or where Federal, State or Local law i:equires us, we will not disclose your health information other than with your written authori7lltion. You may revoke !hat authorization in writing at any time.

Restric:tlom
Your have the right to request restrictions on certain USal and disclosure or YOW' health infonnatioo. Our office will make: r:vecy effort to honor reasonable restriction preferences from our patients.

Conftdendal Communlcattoas
You have the right to request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable request fur confidential communications.

Inspect and Copy Yaar Beuth Information
You have the right to read, review and copy your health information, including yOUT complete: chart, x-rays and bifling records. If you would like a cq,y of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Hcaltb laformadon
You have the right to ask us to update or modify your records if you believe your health infotmation records are inoorrect or incomplete. We will be happy to accommodate you as ling as our office maintains this information. Inorder to standanlize our process, plc:asc: provide us with yom request in writing aud de&enoc your reason for the change. Your request may be dmicd if health information record in question was not created by our office, is not pan of our records or in the records containing your health infonnation are detennincd to be accurate and complete.

Documeatation of Health Information
You have the right to ask us for a description of bow and where your health information was used by our office for any reasOD other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period foe which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable tee for your uest.

Request a Paper Copy of This Notice
You have the right to obtain a copy of the Notice of Privacy Practices Directly from OUT office at any time. Stop by or give us a call and we will mail or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures de5cribed in this notice but we do reserve the right to change the terms of our Notice. Ifwe change our privacy practices we will be sure ail 01'our patients .receive a copy 01' the n,viscd Notice. You have the right to express complaints to us or the Secretas:y of Health and Human Services is you believe your privacy rights have been compromi&ed. We encourage you to express ony concerns you may have regarding the privacy of your infurmation. Plca&e let us know of your concerns or complaints in writing

Patient Acknowledgement

Patient Name(s)_______________________

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we w.int to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this form. We look forward to seeing you soon!

Patient Signature ____________________ Date ____________