



Patient Information Form

First Name: _____ MI: _____ Last Name: _____

Date of Birth: ____ / ____ / ____ SSN: _____

Gender: Male Female Other: _____

Marital Status: Single Married Divorced Widowed

Patient Contact Information

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers:

Mobile: _____ Home: _____ Work: _____

Email: _____

Occupation / Employer: _____

Emergency Contact

Name: _____ Relationship: _____

Phone: _____

How did you hear about us? Friend Patient Google Insurance Walking/driving by the office

Communication Preferences

For your convenience, our office can communicate with you about your health and our office by email and text message.

It is okay for our office to communicate with you by **text message**:

Yes No

It is okay for our office to communicate with you by **email**:

Yes No

Responsible Party Information

The Responsible Party is the person financially responsible for the patient (Guarantor).

Who is the Responsible Party?

Self Another Person

Responsible Party Details *(If you are the Responsible Party, you do not need to re-enter your information.)*

Relationship to Patient: Self Parent Guardian Spouse Other: _____

First Name: _____ MI: _____ Last Name: _____

Date of Birth: ____ / ____ / ____ SSN: _____

Responsible Party Contact Information

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers:

Mobile: _____ Home: _____ Work: _____

Email: _____

Responsible Party Communication Preferences

It is okay for our office to communicate with the Responsible Party by **text message**:

Yes No

It is okay for our office to communicate with the Responsible Party by **email**:

Yes No

Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

Signature: _____ Date: _____

Relationship to Patient:

Self Parent Guardian Spouse Other: _____



Annual Medical History Form

Patient Name: _____ DOB: ____/____/____

Disclaimer - 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 medications that you may be taking, may have an important relationship with the dental care you receive. Thank you for answering the following questions.

Primary Care Physician's Name: _____

Are you currently under the care of a physician Yes No If yes, please explain: _____

Have you ever been hospitalized/had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills or drugs? Yes No If yes, please provide us a list or list it here: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No Do you use tobacco? Yes No

Have you taken Fosamax, Boniva, Actonel, or any other bisphosphonates? Yes No Do you use controlled substances? Yes No

Are you on a special diet? Yes No

Do you use controlled substances? Yes No

WOMEN ONLY - Are you...

Pregnant? Yes No If yes, number of weeks: _____

Trying to get pregnant? Yes No

Taking oral contraceptives? Yes No Nursing? Yes No

ALLERGIES - Are you allergic to or have you had a reaction to any of the following? (If yes, please explain.)

Aspirin Yes No Acrylic Yes No

Penicillin or other antibiotics Yes No Codeine or other narcotics Yes No

Metals Yes No Latex (rubber) Yes No

Sulfa drugs Yes No Local anesthetics / Epinephrine Yes No

Other: Yes No _____

Medical Information - Please answer if you have or have had any of the following diseases or conditions.

AIDS / HIV Yes No Diabetes Type II Yes No

Anemia Yes No Eating disorder Yes No

Anxiety Yes No Emphysema Yes No

Arthritis Yes No Epilepsy or seizures Yes No

Asthma Yes No Excessive bleeding Yes No

- Bronchitis Yes No Frequent headaches Yes No
- Bruise easily Yes No Herpes Yes No
- Depression Yes No Gastrointestinal disease Yes No
- Diabetes Type I Yes No GERD / Acid reflux Yes No
- Glaucoma Yes No Hemophilia Yes No
- High blood pressure Yes No Immune deficiency Yes No
- Kidney problems Yes No Liver disease Yes No
- Low blood pressure Yes No Lupus Yes No
- Malnutrition Yes No Mental health disorders Yes No
- Neurological disorders Yes No Osteoporosis Yes No
- Pain in jaw joints Yes No PTSD Yes No
- Rheumatoid arthritis Yes No Sexually transmitted infections Yes No
- Sinus trouble Yes No Stomach ulcers Yes No
- Traumatic brain injury / Concussion Yes No Thyroid disease Yes No
- Tuberculosis Yes No Vertigo Yes No
- Yellow jaundice Yes No

If you have, or have been diagnosed with, any of the following conditions, please give explanation (e.g: date and type)

- Artificial joint Yes No If yes, please explain: _____
- Pacemaker / Implanted defibrillator Yes No If yes, please explain: _____
- Artificial (prosthetic) heart valve Yes No If yes, please explain: _____
- Previous infective endocarditis Yes No If yes, please explain: _____
- Congenital heart disease Yes No If yes, please explain: _____
- Coronary artery disease Yes No If yes, please explain: _____
- Congestive heart failure Yes No If yes, please explain: _____
- Heart murmur / rhythm disorder Yes No If yes, please explain: _____
- Rheumatic heart disease Yes No If yes, please explain: _____
- Stroke Yes No If yes, please explain: _____
- Cancer Yes No If yes, please explain: _____
- Chemotherapy Yes No If yes, please explain: _____
- Radiation treatment Yes No If yes, please explain: _____
- Blood transfusion Yes No If yes, please explain: _____

Have you ever had any serious illness not listed above? Yes No **If yes, please explain:** _____

COMMENTS: _____

To the best of my knowledge, the information provided on this form is accurate and complete. I understand that providing incorrect information may be dangerous to my (or the patient’s) health. I agree to inform the dental office of any changes in my medical status.

Signature: _____ **Date:** ____ / ____ / ____

Print Name if Parent or Guardian: _____



Self-Pay / Dental Insurance Information Form

Patient Name: _____ DOB: ____/____/____

Insurance Information

Do you have dental insurance or will you be paying for yourself? Self-Pay I have Dental Insurance

Primary Dental Insurance

Insurance Company Name: _____ Type of Plan: _____

Subscriber ID: _____ Group Number: _____

Subscriber Information

Relationship to Patient: Self Parent Guardian Spouse Other: _____

To be answer only if the Subscriber is not the patient:

Subscriber Name: First: _____ Last: _____

Date of Birth: ____ / ____ / ____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer Information

Is this plan through an employer? Yes No - If yes, Employer's Name: _____

Secondary Dental Insurance

Do you have secondary dental insurance you would like to use? Yes No *(If no, skip the section below.)*

Insurance Company Name: _____ Type of Plan: _____

Subscriber ID: _____ Group Number: _____

Subscriber Information

Relationship to Patient: Self Parent Guardian Spouse Other: _____

To be answer only if the Subscriber is not the patient:

Subscriber Name: First: _____ Last: _____

Date of Birth: ____ / ____ / ____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer Information

Is this plan through an employer? Yes No If yes, Employer's Name: _____

Dental Insurance Assignment & Release

I certify that I, and/or my dependent(s), have insurance coverage with the company(ies) above and assign directly to the dentists at New Horizons Family Dental and/or Vibhi Vellanki Inc 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 my 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.

Acknowledgment and Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: _____ Date: _____

Relationship to Patient:

Self Parent Guardian Spouse Other: _____

GENERAL DENTISTRY INFORMED CONSENT FORM

1. EXAMINATION AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

2. DRUGS, MEDICATION, AND SEDATION

I have been informed and understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. CHANGES IN TREATMENT PLAN

I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

4. TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ)

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

5. FILLINGS

I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.

6. REMOVAL OF TEETH (EXTRACTION)

Alternative to removal has been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the tooth and any others necessary for the reasons in paragraph #3. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved is having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

7. CROWNS, BRIDGES, VENEERS AND BONDING

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

8. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be “teeth in wax” try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

9. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

10. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

CONSENT: *I understand that dentistry is not an exact science, therefore: reputable parishioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.*

Patient Name (Print): _____

Signature of patient, Parent or Guardian: _____ Date: _____

Print name if Parent or Guardian: _____



OFFICE POLICIES

Dental Insurance: Submission of insurance claims is a COURTESY that our office provides but not an obligation. We can only ESTIMATE what the insurance will cover based on what they tell us. Each insurance company has their policies for benefits and exclusions. It is the patient's responsibility to familiarize themselves with the type of coverage and limitations of their insurance policy. Co-payments are due at the time that services are rendered unless other financial arrangements have been made. Therefore, it is the patient's responsibility for the difference in payments. We will not be held responsible for charges incurred after the maximum has been exceeded, waiting periods, clauses and/or benefit termination.

Recall/Hygiene Appointments: Our office adheres to ADA recommendations in regards to x-rays and dental cleanings which are: full mouth x-rays or panoramic once every 3 to 5 years; bitewing x-rays every 6 to 12 months and dental cleanings twice per year (every 6 months) MINIMUM. Please keep in mind that two cleanings per year is the minimum. Each individual has different needs based on the health of their mouth.

Refusal of Treatment, Exams and X-rays: There is a standard of care that our office must adhere to. It is impossible for us to make a proper diagnosis and treatment plan without current x-rays and a dental examination. It is our OBLIGATION to inform you of existing problems in your mouth, therefore, all patients who refuse exams and appropriate x-rays should seek help elsewhere as our office would not be able to provide you with the quality of care that we believe in. All patients are welcome to seek a second opinion elsewhere. For those who refuse treatment, it is certainly your right, and therefore we would kindly ask you to sign a LETTER of REFUSAL for treatment which states that our office has informed you of the need of treatment and the possible consequence if left untreated and that you are fully aware of the consequence and would take full responsibility of it.

Request for Copy of Records: Our office provides up to two (2) electronic copies of your dental record at no charge. These records include radiographs taken in our office and clinical notes from your chart. If you request more than two copies, a fee will apply in accordance with our fee schedule. Please allow up to 5 business days for the preparation and delivery of your records.

Broken Appointment: We have a STRICT cancellation policy. We do not overbook patients in anticipation of no-shows or last minute cancellations therefore it is important that you keep scheduled appointment. We understand that last minute changes in your schedule may be unavoidable and we will try to accommodate those changes if possible. However, when appointments are scheduled our dentist's and/or hygienist's time is reserved for you and it is unavailable to other patients who need to schedule an appointment. We strive to see patients on time for scheduled appointments; however there are times when our schedule is delayed in order to accommodate an emergency or complication in a scheduled procedure. Please accept our apology should this occur during your appointment.

Follow our standard policy for broken appointments:

Broken/Missed Appointments: There is a **\$50** broken appointment **fee** for missed appointments or cancelled with less than **48 hours notice**. Please note that if you need to cancel appointments that are scheduled on a Monday, our office needs to be **notified by Thursday at noon time as our office is closed on the weekends. If 2 broken appointments occur, our office reserves the right to not schedule any subsequent appointments for you.**

Reminder of Appointments: Reminder of appointments is a COURTESY that our office provides not an OBLIGATION. We suggest that you call our office if you are unsure of the time and/or date of your appointment because there WIL BE a broken appointment charge if you do not show up.

I have read and fully understand and agree with the broken appointment policy of Vibhi Vellanki ,Inc.

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 February 16, 2026 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.

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 use disorder treatment 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 participate 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.

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:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- 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 perform 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.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2

Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

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 acted 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 Practices Acknowledgement (HIPPA): I understand and acknowledge my rights as detailed in the Notice of Privacy presented here.

Patient Name (Print): _____

Signature of patient, Parent or Guardian: _____ Date: _____

Print name if Parent or Guardian: _____