Artiste Dentistry LLC

We are pleased to welcome you to our practice. Please take a few minutes to complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name: (Last, First, MI) _____ Age: ____ Sex: □M □F
Address: _____ Apt No._____
City: _____ State: _____ Zip: _____
Birth Date: ____/____/_____ SSN: _____-_____-_____Single / Married/ Divorced /Widowed
Drivers License No: _____ State: _____ E-mail:_____
Employer / Occupation: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Are any of your family members patients of this practice? □Yes □No Name: _____ Relationship: _____
Whom may we thank for referring you to our office? _____
□Insurance Directory □Other Patient_____ □Direct Mail □Yellow Pages □Internet Search □Other _____

Home: (_____) _____-_____
Work: (_____) _____-_____
Mobile: (_____) _____-_____

In case of emergency, contact:_____ Relationship:_____ Phone (_____) _____-_____

Primary Insurance

Person Responsible for Account: (Last, First, MI) _____
Relationship to Patient: _____
Address (if different from Patient's):_____ Apt No._____
City: _____ State: _____ Zip: _____
Birth Date: ____/____/_____ SSN: _____-_____-_____ Married / Single / Other
Drivers License No: _____ State: _____ E-mail:_____
Person Responsible Employed By_____Occupation:_____
Employer Address: _____ City: _____ State: _____ Zip: _____
Insurance Company: _____Group Name: _____Plan:_____
Contract #:_____Group #:_____Subscriber #:_____
Insurance Claims Dept. Address_____Phone #:_____
Names of other dependents covered under this plan _____

Home: (_____) _____-_____
Work: (_____) _____-_____
Mobile: (_____) _____-_____

Dental History

What is the reason for this appointment? _____
Are there any specific dental problems we should be aware of? _____
Do you think you have any decay or cavities? □Yes □No
Do your gums bleed easily when brushing or flossing? □Yes □No
Do you suffer from chronic bad breath or bad taste? □Yes □No
Are you happy with the appearance of your teeth? □Yes □No
Do you suffer from snoring & sleep apnea? □Yes □No
How often do you brush? _____
How often do you floss? _____
Do you have any jaw joint cracking or pain? □Yes □No
Have you ever considered whitening your teeth? □ Yes □ No
* If "yes" please fill out "Epworth Sleepiness Scale" Form*
What was the purpose of your last dental appointment? _____When was that? _____
When was the last time you had a dental cleaning? _____ Name of previous dentist? _____
When were the last full mouth x-rays taken of your teeth? _____
How would you describe your dental health? □Excellent □Good □Fair □Poor

Patient Treatment Consent

- ❑ I authorize the Dentist(s) or designated staff treating me or my dependents to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of any dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- ❑ I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.
- ❑ I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment will be assessed a service charge of **$25 per month**.

Patient / Parent or Guardian Signature: _____ Date: _____

Medical History

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Do you have, or have you ever been treated for:

Any heart problems	☐Yes ☐No
Heart murmur	☐Yes ☐No
Mitral valve prolapse	☐Yes ☐No
Heart valve defect	☐Yes ☐No
Heart valve replacement	☐Yes ☐No
Rheumatic fever	☐Yes ☐No
Artificial joint (hip / knee)	☐Yes ☐No
Angina	☐Yes ☐No
Stroke	☐Yes ☐No
Heart attack	☐Yes ☐No
Bypass	☐Yes ☐No
Pacemaker	☐Yes ☐No
High blood pressure	☐Yes ☐No
Low blood pressure	☐Yes ☐No
Any bleeding disorders	☐Yes ☐No
Anemia	☐Yes ☐No
Hemophilia	☐Yes ☐No
Sickle cell trait	☐Yes ☐No
Blood transfusions	☐Yes ☐No
Do you smoke	☐Yes ☐No
Lung / breathing problems	☐Yes ☐No

Asthma	☐Yes ☐No
Bronchitis	☐Yes ☐No
Emphysema	☐Yes ☐No
Tuberculosis	☐Yes ☐No
Sinus trouble	☐Yes ☐No
Difficulty in healing	☐Yes ☐No
Diabetes	☐Yes ☐No
Thyroid problems	☐Yes ☐No
Adrenal/pituitary problems	☐Yes ☐No
Liver problems	☐Yes ☐No
Hepatitis / Jaundice	☐Yes ☐No
Kidney problems	☐Yes ☐No
Stomach trouble / ulcers	☐Yes ☐No
Nervous or mental disorder	☐Yes ☐No
Epilepsy or seizures	☐Yes ☐No
Alcoholism	☐Yes ☐No
Drug abuse	☐Yes ☐No
Cancer / tumor	☐Yes ☐No
Other growths	☐Yes ☐No
Chemo / radiation therapy	☐Yes ☐No

Sexually Transmitted Diseases	☐Yes ☐No
Other infectious diseases	☐Yes ☐No
HIV / AIDS	☐Yes ☐No
Are you pregnant?	☐Yes ☐No
Are you nursing?	☐Yes ☐No
Allergic reaction (hives / selling) to:	
Penicillin	☐Yes ☐No
Erythromycin	☐Yes ☐No
Sulfa	☐Yes ☐No
Codeine	☐Yes ☐No
Aspirin	☐Yes ☐No
Latex	☐Yes ☐No
Local anesthetic (Novocain)	☐Yes ☐No
Nickel or other metals	☐Yes ☐No
Other medications or substances? Please list: ________________ ________________ ________________	☐Yes ☐No

Do you need to take antibiotic pre-medication prior to dental appointments? ☐Yes ☐No ☐Don't know Name of antibiotic:________________

Are you currently being treated by a physician? ☐Yes ☐No For what reason:____

Physician's name, address and phone number: ____

Are you presently taking any medications, pills, or tonics? (i.e., Blood pressure, birth control, steroids, hormones) ☐Yes ☐No

Medication	For	Medication	For

Is there any condition or problem relating to your medical history that has not been mentioned? ☐Yes ☐No
Explain:

____

____

>>

☐ I certify that the above information is complete and accurate to the best of my knowledge. I will inform the dentist of any changes in my health status or my medications.

Date: __________________ Patient/Parent or guardian signature:_______________________________

Doctor/hygienist signature: _________________________________

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Initial Review of Patient Medical History (Office Use Only)

	Yes	No	Reviewer Notes
Medical Alert Recommended	☐	☐	
Pre-Medication Recommended	☐	☐	

Rx: ____

Patient Smile Evaluation Form

Name:_____Date:_____

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please circle your answer.

Do you dislike the color of your teeth?	YES NO
Do you have spaces between your teeth that bother you?	YES NO
Do you have chips or uneven edges on your teeth?	YES NO
Do you feel that your teeth are too long or too short?	YES NO
Do you have dark fillings that show when you smile?	YES NO
Do your gums show too much when you smile?	YES NO
Are your teeth crowded or crooked?	YES NO
Do you have existing crowns or dental work you consider "ugly"?	YES NO
Are you self-conscious of your teeth and/or smile?	YES NO
Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile?	YES NO
Do you avoid smiling when you have your picture taken?	YES NO
Would you like to improve your existing smile?	YES NO
Do you wish you had a "new smile"?	YES NO

Place a checkmark next to which of the following are concerns you have regarding dental treatment to improve your smile:

Fear of treatment
Time of treatment concerns
Financial concerns
Distance to office
Not understanding treatment
Embarrassment
Other

Patient Name (PRINT) _____

Section 1: Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations:
(0=never, 1=slight, 2=moderate, 3=high chance of dozing) – CIRCLE ONE RESPONSE FOR EACH QUESTION

Sitting and reading……	0	1	2	3
Watching television……	0	1	2	3
Sitting in a public place……..0		1	2	3
As a passenger in a car for one hour……..0		1	2	3
Driving a car stopped for a few minutes in traffic……..0		1	2	3
Sitting & talking to someone……0		1	2	3
Sitting down quietly after lunch without alcohol…… 0		1	2	3
Lying down to rest in the afternoon……0		1	2	3

Total Score: _____

Section 2: Patient Evaluation

Fill in the blanks, circle one yes or no response for each question

			No(0)	Yes(1)
BMI (See Attached Chart):	_____	Is it greater than or equal to 30?	0	1
Neck Circumference	_____	Is it >17" (Men) or >15"(Women)?	0	1
Have you gained at least 15lbs in the past 6 months?			0	1

Total Score: _____

Section 3: Subjective Sleep Evaluation

Please circle one yes or no response for each question

	No(0)	Yes(1)
Do you snore?.....0		1
You, or your spouse, would consider your snoring louder than a person talking….0		1
Your snoring occurs almost every night…….. 0		1
Your snoring is bothersome to your bed partner…….....0		1
Do you feel that in some way your sleep is not refreshing or restful?..... 0		1
Do you wake up at night or in the mornings with headaches?..... 0		1
Do you experience fatigue during the day and have difficulty staying awake?..... 0		1
Do you have trouble remembering things or paying attention during the day?..... 0		1
Do you have high blood pressure?..... 0		1

Total Score: _____

Section 4: Prior Diagnosis

	No(0)	Yes(1)
Have you previously been diagnosed with sleep apnea?	0	1

If Yes:

When were you diagnosed? (Approx mo/yr) _____
Were you put on CPAP Therapy for treatment? _____
Are you still using your CPAP every night? _____

Total Score: _____

Notes: (Please insert any notes for the doctor regarding snoring, sleep patterns or sleep apnea that you feel may be appropriate use back of page if necessary.)

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

OFFICE USE ONLY

Advanced screening criteria, if yes to any below pt should be scheduled for advanced OSA screening.
_____ ESS Score ≥ 8? _____ Pt. Eval ≥ 2? _____ Subjective Sleep Eval ≥ 3? _____ Prior OSA Diagnosis ≥ 1?

Body Mass Index Table

	Normal						Overweight					Obese										Extreme Obesity																				
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (inches)	5 ft= 60inches, 6ft = 72inches						Body Weight (pounds)																																	
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Source: Adapted from *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report*.

The primary goal of our practice is to provide the highest quality dental care to our clients. Since our practice also has financial obligations which must be met, we ask you to note the following statements of our financial policy.

Important Dental Insurance Information for our Patients:

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles, and required co-payments.
Your insurance plan is a contract between you (or your employer) and the insurance company. Ultimately, patients are financially responsible for their accounts. Specific questions about eligibility and plan coverage should be directed to your insurance or your employer.

Treatment Plans and Estimates:

Treatment plans are merely estimates. We may encounter situations during the course of your planned treatment that may require different and/or additional procedures. It is often impossible to predict the *exact* cost of the treatments until they are rendered.

Our Courtesy Service to you includes:

. Researching your dental insurance plan to advise you of benefits available to you.
. Following the American Dental Association guidelines for coding procedures and filing insurance.
. Filing your insurance on your behalf within 48 hours of your visit and requesting payment of your benefit to our office.

Our expectations of you as the Owner of the Policy:

. Payment of fees not covered by your insurance plan at the time the services are rendered including deductibles and co-payments. All co-pays are an **estimate** of your benefits; your actual coverage may be less. In the event that your insurance carrier pays less than the estimated amount, you are responsible for the unpaid balance. 2% Finance Charge will be applied to unpaid account balances every month.

Note: Deductibles & Co-payments are due in full at time of services rendered. Invoices are only generated for unpaid balances after insurance payments have been made on a claim.

. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called *Usual & Customary Rates*) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance not our fees or recommended treatment.
. Taking responsibility for payment if the insurance company does not pay our office within 30 days.
. Keeping our office informed of any changes in your insurance coverage or employment.

Emergency Services:

. All efforts will be made to accommodate emergency visits as soon as possible; but in some cases patients will have to wait for the next available appointment if appointments are made over the phone or wait for more than 30 minutes or until the dentist becomes available if visiting without a prior notice.
. Due to the nature of emergency visits, new patient emergency treatments will only be accepted if patient covers the charges of the service at the time the service is rendered.
. Post-operative complications of another dentist's treatment will not be treated and patient should seek treatment under the care of the dentist who has initiated the treatment.
. Medications will not be prescribed over the phone for new emergency patients that have not been visited by the dentist. Only in some established cases with patients of record medications not including heavy narcotics will be prescribed over the phone.

Termination Policies:

The dentist-patient relationship may terminate if:

.Treatment recommendation is refused by the patient and the dentist can no longer continue to care for the patient at or above the standard of care.

. Patient falsifies and fabricates information documented in his/her records.

. Patient doesn't fulfill his/her financial obligations and stops making payments for services.

. Patient misses or cancels numerous appointments.

. Patient makes unreasonable demands on dentist and his/her staff.

In the event of termination of dentist-patient relationship, the patient will be informed & assisted during the termination of the relationship. Emergency care will be provided for 30 days from the date of termination.

Missed Appointment & Cancellation Policies:

. Each missed appointment without 48 hour notice in advance will be subject to $25 per 30 minute of appointment.

***After your first missed appointment with less than 48 hour in advance notice, it is our policy to secure a down payment of $25 per 30 minute of future booked appointments.**

. As a courtesy to you we have a patient appointment reminder service in place. If you have any questions about your appointment or if there is any discrepancy, you should ALWAYS verify by calling our office.

. Remembering your appointment date and time is ultimately your responsibility. Not getting a reminder is neither an excuse to miss your appointment nor will it invalidate your originally set appointment.

. Rescheduling & cancelling appointments are ON LY accepted via phone calls & NOT accepted via text or email.

Administrative Charges:

Checks returned by the bank	$35 per returned check
Finance Charge applied to unpaid balances (each month)	2% per month
Missed appointments per 30 min of appointment (unless notice is given 48 hours in advance)	$25 per 30 minutes
*****Down payment per 30 min of booked procedure appointment	$25 per 30 minutes
Collection agency fee (not including attorney & court costs)	$50 or 40% charge on unpaid balance, whichever is greater

Payment Options:

Our primary mission is to deliver the best and most 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 offering several payment options.

Our office accepts: Cash or Cashier's check, Personal check (with established patients), Visa®, MasterCard®, American Express® or Discover Card®

For extensive treatment plans with an out of pocket expense more than $1,000 our office offers the following:

1. We offer a 5% courtesy accounting adjustment to patients who pay for their treatment in full at the time of service with **NO** insurance coverage.
2. Recurring pay financing (with added 2.99% recurring fee)- with 3 payments, one month apart with 2 form of payments, a credit card, debit card or bank account on file at the office. Alternate arrangements may be made with out of pocket expenses more than $5,000.
3. CareCredit® Healthcare Credit Card- Special financing options with convenient monthly payments with following features:
   - Allows you to pay over time
   - Has no annual fee, no application fee, and no required down payment
   - Interest-free loans up to twelve months

**Applications and additional information for CareCredit are available from our receptionist.*

I hereby authorize Artiste Dentistry LLC to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Artiste Dentistry LLC.
I have read this financial policy. I understand and agree to the terms of this financial policy.

_____ _____

Signature of Patient (or Financially Responsible Party) *Date*

Please Read Both Pages Carefully, Sign & Date

Acknowledgement Of Receipt Of Notice Of Privacy Practices

I have received a copy of the Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name: _____

Relationship to Patient: _____

NOTICE OF PRIVACY PRACTICES

Artiste Dentistry LLC
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect October 1, 2005, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you at your next office.
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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care and service that you receive. Your health information is contained in a medical or dental dispensary record that is the physical property of Artiste Dentistry.

How We May Use or Disclose Your Health Information

For Treatment

We may use or disclose your health information to another health care facility with specialty in oral surgery, endodontics, maxillofacial surgery, periodontics, pediatric dentists, or other healthcare providers providing treatment to you for:
. the provision, coordination, or management of health care and related services by health care providers;
. consultation between health care providers relating to a patient/customer;
. the referral of a patient for health care from one health care provider to another; or
. appointment reminders and recall information.

For Payment

We may use and disclose your health information to others for purposes of processing and receiving payment for treatment and services provided to you. This may include:
. billing and collection activities and related data processing;
. actions by a health plan or insurer to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims;
. medical necessity and appropriateness of care reviews, utilization review activities; and
. disclosure to consumer reporting agencies of information relating to collection of payments.

For Health Care Operations

We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to:
. evaluate the performance of our associates;
. assess the quality of service, product and care in your case and similar cases;
. learn how to improve our facilities and services;
. conduct training programs or credentialing activities; and
. determine how to continually improve the quality and effectiveness of the products, service and care we provide.

Appointments, Treatment and Quality Assurance

We may use your information to provide appointment reminders or recall notices (such as voicemail messages, postcards or letters) or information about treatment alternatives or other health-related benefits, products and services that may be of interest to you. We may also contact you to conduct our own surveys about the quality of the products and services we provide.

To You, Your Family and Friends

We must disclose your health information to you, as described in the Your Health Information Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so or, if you are not able to agree, if it is necessary in our professional judgment.

Persons Involved in Care
We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location or your general condition. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. 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 pick up filled prescriptions, medical supplies, photos, x-rays, or other similar forms of health information.

Required by Law
We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:
. for judicial and administrative proceedings pursuant to legal authority;
. to report information related to victims of abuse, neglect or domestic violence;
. to assist law enforcement officials in their law enforcement duties; or
. to assist public health officials avert a serious threat to the health or safety of you or any other person.

Decedents
Health Information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation
Your health information may be used or disclosed for cadaver, organ, eye or tissue donation purposes.

Research
We may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Government Functions
Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Worker Compensation
Your health information may be used or disclosed in order to comply with laws and regulations related to Worker Compensation.

Marketing Health Products or Services
We will not use your health information for marketing communications without your prior written authorization. We may, however, provide you with information regarding products or services that we offer related to your health and oral care needs. We will never sell your health information without your prior authorization.

Your Authorization
In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

YOUR HEALTH INFORMATION RIGHTS

Access:
You have the right to review or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You may be asked to make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice setting forth the specific information to which you desire access. If you request an alternative format, provided that it is practicable for us to produce the information in such format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting:
You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, where you have provided an authorization and certain other activities, for the last 6 years, but not for disclosures made prior to April 14, 2003. 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 these additional requests.

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

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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. You may obtain a form to request an amendment to your health information by using the contact information listed at the end of this Notice.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Information

If you have any questions or complaints, please contact:

Artiste Dentistry LLC
46090 Lake Center Plaza, Suite 107
Phone: 703-434-3286
Email: Info@ArtisteDentistry.com

Thank you for entrusting Artiste Dentistry LLC with your dental and oral care needs.