TEBO DENTAL

Phone: 770.925.3300 | TeboDental.com

## Informacion del Paciente

### Padre O Encargado Paciente (si el paciente es menor de edad)

Como escucho de nosotros?_____

Nombre _____ Relación al Paciente _____
Apellido Nombre Inicial

Fecha de Necimiento _____ Número de Seguro Social _____
Mes/Dia/Año

Estado marital de los padres: ☐ Casados ☐ Soltero ☐ Separado ☐ Divorciado ☐ Viudo

Números de Teléfono: Número primario _____ Número secundario _____

Dirección _____
Ciudad Estado Código Postal

Correro electronico _____ Cual es su metodo de comunicacion prefido? ☐ Correo electronico ☐ Mobil ☐ Trabajo ☐ Casa ☐ Texto

Ocupación _____ Empleador _____ ¿Cantidad de tiempo empleado? _____

Persona a quien llamar en caso de emergencia (que no radique en el mismo hogar)

Nombre _____ Relación al Paciente _____
Apellido Nombre Inicial

Números de Teléfono: Número primario _____ Número secundario _____

Certifico que la información arriba mencionada y anexa es verdadera y correcta.

Firma del paciente o persona responsable _____ Fecha _____

### Datos Demograficos Del Paciente

Nombre _____ ☐ M ☐ F Fecha de Nacimiento _____ Edad _____
Apellido Nombre Inicial Mes/Dia/Año

Dirección _____ Nivel Escolar _____
Ciudad Estado Código Postal

Hermanos/as _____ School _____
Nombres y edades

Pasatiempos _____ Alergias/Medicamentos _____
hobbies, deportes, mascotas, etc

Usted es Hispano o Latino? Si / No

Lenguaje preferido _____

Religion _____

Cual es su raza?

☐ Indo Americano o Nativo de Alaska ☐ Nativo de Hawaii v otras islas del Pacifico

☐ Asiatico

☐ Negro o Americano Africano ☐ Blanco

### Informacion De El Seguro Medico

Tiene seguro dental? ☐ Si ☐ No

Nombre del Asegurado _____ Fecha de Necimiento _____ Número de Seguro Social _____
Apellido Nombre Inicial Mes/Dia/Año

Relación al Paciente _____ Nombre del Empleador _____

Tel. del Trabajo _____ Número y Nombre del Grupo _____

Nombre de la compañía de seguro _____

Dirección de la compañía de seguro _____
Ciudad Estado Código Postal

### Informacion de el Seguro Medico Secundario

Nombre del Asegurado _____ Fecha de Necimiento _____ Número de Seguro Social _____
Apellido Nombre Inicial Mes/Dia/Año

Relación al Paciente _____ Nombre del Empleador _____

Tel. del Trabajo _____ Número y Nombre del Grupo _____

Nombre de la compañía de seguro _____

Dirección de la compañía de seguro _____
Ciudad Estado Código Postal

## Historia Dental

Nombre _____

La razón de su visita hoy _____

TEBO DENTAL

## Historial Dental Y Medico

1. ¿Es esta la primera visita al dentista de su hijo(a)? ____ No ____ Si
2. ¿Opina usted que su hijo(a) cooperará en esta visita? ____ No ____ Si
   No es así explique: _____
3. ¿Toma su hijo(a) gotas o tabletas con fluoruro o vitaminas con fluoruro? ____ No ____ Si
4. ¿Se ha lastimado su hijo(a) algun diente? ____ No ____ Si
   No es así explique: _____
5. ¿Sufre su hijo(a) de dolores de cabeza, o dolor en la mandibula? ____ No ____ Si
6. ¿Toma todavia su hijo(a) una mamila de leche o jugo en la noche? ____ No ____ Si
7. ¿Tiene su hijo(a) dolor de dientes? ____ No ____ Si
8. ¿Mantiene su hijo(a) los labios entreabiertos mientras se encuentra relajado? ____ No ____ Si
9. ¿Al masticar alimentos mantiene su hijo(a) la boca abierta? ____ No ____ Si
10. ¿Al beber liquidos hace su hijo(a) sonidos? ____ No ____ Si
11. ¿Su hijo(a) respira por la boca? ____ No ____ Si
12. ¿Come su hijo(a) todo tipo de alimentos? ____ No ____ Si
13. ¿Evita su hijo(a) masticar carnes ó alimentos duros? ____ No ____ Si
14. ¿Su hijo(a) ronca? ☐ Siempre ☐ A Veces ☐ Nunca

Por favor indique si su hijo(a) ha tenido o tiene algunos de estos problemos o habitos:

____ Chuparse el pulgar Hace cuánto tiempo? _____ Todavía lo hace? ____Si ____ No
____ Chuparse los dedos Hace cuánto tiempo? _____ Todavía lo hace? ____Si ____ No
____ Claupón Hace cuánto tiempo? _____ Todavía lo hace? ____Si ____ No

## Historia Medico

Médico o pediatra primario del paciente _____

Dirección _____ Teléfono _____
Ciudad Estado Código Postal

1. ¿Esta su hijo(a) en buen estado de salud? ____ No ____ Si
2. ¿Esta su hijo(a) bajo el cuidado de un médico por alguna condición médica? ____ No ____ Si
   Si es así explique: _____
3. ¿Su hijo tiene alergias al huevos, leche, o productos derivado de la soya? ____ No ____ Si
4. ¿Su nino tiene algunas otras alergias? ____ No ____ Si
   Si es así explique: _____
5. ¿Que tan severo, en la escala del 1 al 10? _____
6. ¿Esta su hijo(a) tomando algun medicamento en este momento? ____ No ____ Si
   Si es así explique: _____
7. ¿Ha sido su hijo(a) hospitalizado o tratado en una sala de emergencia? ____ No ____ Si
   Si es así explique: _____ (cuando y por cual razón)
8. ¿Su nino(a) tiene o ha tenido algun desorden emocional, mental, o nervioso? ____ No ____ Si
   Si es así explique: _____ (cuando y por cual razón)
9. ¿Le han removido a su hijo(a) las agmindalas ó adenoides? ____ No ____ Si
   Si es así explique: _____

Por favor indique si su hijo(a) tiene o ha tenido lo siguiente:

| | | | | | |
|---|---|---|---|---|---|
| ☐ Asma | ☐ Problemas de habla | ☐ Limitación Física | ☐ HIV Positivo | ☐ Tuberculosis | ☐ Desorden de Déficit de Atención |
| ☐ Hyperactivdad | ☐ Soplo del Corazón de que tipo? _____ | ☐ Limitación Mental | ☐ Diabetes | ☐ Desorden Endocrino | ☐ Problemas del hígado/ hepatitis |
| ☐ Alergias al alimento/polen | | ☐ Transfusión de Sangre | ☐ Epilepsia | ☐ Desorden Oseo | ☐ Leucemia |
| | | ☐ Fiebre Reumática | ☐ Desordenes Sanguineos | ☐ Paladar Hendido | ☐ Terapia de Radiación |

¿Esta el niño(a) bajo el cuidado de un cardiólogo o médico especializado en este problema? Si es así, nombre del doctor: _____

Usted como considera el aprendizaje se su hijo(a)? ☐ Avanzado ☐ Normal ☐ Lento

Favor de incluir la información médica adicional que usted considere importante:

_____

_____

## Consentimiento Medico

Doy mi consentimiento a servicios dentales necesarios, anestesicos locales, óxido nitroso y el uso de metodos aceptables y apropiados para completar el tratamiento. De igual modo acepto la responsabilidad por el pago de tales servicios.

Nombre del paciente _____ Firma del Padre/Tutor: _____ Fecha _____

# Acuerdo de Pago y Citas

Los términos de este acuerdo se aplican a todas las ubicaciones de Tebo Dental Group ("nosotros", "nuestras oficinas" o palabras a tal efecto), incluyendo Tebo Dentistry for Kids Lilburn, Tebo Dentistry for Teens, Tebo Dentistry for Kids Gainesville, Tebo Dentistry for Kids Dacula and Tebo Dentistry for Kids Peachtree Corners, Tebo Orthodontics Lilburn, Tebo Orthodontics Dacula, Tebo Orthodontics Peachtree Corners y cualquier consultorio dental en el future que abramos.

**Nuestros Cargos**

Usted (el suscrito) acepta pagar todos los cargos relacionados con nuestro tratamiento del paciente mencionado a continuación y acepta los términos y condiciones de este acuerdo. Estos cargos incluyen cualquier interés aplicable y los costos y honorarios de cobro por citas que se rompen o cancelan sin el aviso previo escrito a continuación. Si dos o más personas son responsables de los cargos del paciente, entonces todas las personas responsables son responsables solidariamente por tales cargos.

**Reembolsos**

Si le corresponde un reembolso, emitiremos el reembolso de la misma forma que lo hizo con su pago original. Por ejemplo, si pagó con tarjeta de crédito, emitiremos un reembolso a la misma tarjeta de crédito. Como otro ejemplo, si pagó con fondos de una cuenta de Acuerdo de ahorro flexible (FSA), emitiremos un reembolso a la misma cuenta FSA. Si no podemos emitir un reembolso en la misma forma que su pago original, emitiremos un reembolso en cualquier forma que escojamos a nuestra discreción razonable.

**Citas Perdidas o Canceladas**

Si necesita cancelar una cita, notifíquenos al menos un (1) día hábil completo antes de la cita. Por ejemplo, notifíquenos antes de las 9:00 am del viernes para cancelar una cita programada para las 9:00 am del lunes siguiente. Es posible que cobremos $ 50.00 por cada cita perdida o cancelada si no recibimos la notificación previa requerida. Para cancelar una cita, llámenos y hable con nosotros durante el horario de oficina, de lunes a viernes de 8:00 am a 5:00 pm.

**Se Require Pago a la hora de tratamiento**

El pago del tratamiento se requiere en su totalidad al momento del tratamiento, a menos que haya hecho otros arreglos de pago con nosotros. Si presentamos un reclamo de seguro para usted, lea la siguiente sección para obtener una explicación de los acuerdos de pago. Si no puede pagar nuestros cargos en su totalidad, consulte a nuestro personal sobre cualquier financiamiento de terceros disponible.

**Reclamos de Seguro**

Si presentamos un reclamo de seguro para el paciente, deberá pagarnos en el momento del tratamiento, el deducible de seguro esperado y cualquier monto que esperamos que el seguro no cubra. Tratamos de obtener información precisa sobre los beneficios y la cobertura del seguro antes del tratamiento, pero no podemos estar seguros de lo que pagará la compañía de seguros hasta que se presente la reclamación y la compañía de seguros realmente pague la reclamación. No es raro que las compañías de seguros nos brinden información errónea sobre la cobertura o los beneficios. Esto es importante porque debe pagarnos el saldo restante si la compañía de seguros no paga el reclamo por nuestros cargos dentro de los treinta (30) días posteriores a la fecha de servicio

**Cheques Devueltos**

Cobramos $ 30.00 por cualquier cheque que se nos devuelva sin pagar. Además, si nos dio un cheque sin fondos en el pasado, no aceptaremos su cheque personal en el futuro como pago por los servicios.

**Interes en pago atrasados**

Por favor pague todos los cargos a tiempo. Agregamos intereses de 1-1 / 2% por mes a cualquier cargo que no se haya pagado dentro de los treinta (30) días posteriores a la fecha de servicio. Esto se aplica a cualquier cargo que la compañía de seguros del paciente no pague a tiempo. Controle el plan de seguro del paciente para asegurarse de que la compañía de seguros pague los cargos del paciente a la brevedad.

**Cobro de cuentas vencidas por agencia de cobro o abogado**

Si no se paga la cuenta del paciente a su vencimiento y remitimos la cuenta del paciente a una agencia de cobranza o un abogado para su cobro, cobraremos a la cuenta del paciente el monto que debemos pagar a la agencia de cobranza o al abogado para cobrar su cuenta. Las agencias de cobro generalmente cobran una comisión porcentual, que va desde el 30% hasta el 50% del monto total recaudado. Para una comisión del 30%, agregaremos a la cuenta del paciente el 43% de la cantidad de nuestros cargos relacionados con el tratamiento y los intereses devengados para que podamos recuperar nuestros cargos e intereses después de que la agencia de cobranza deduzca su comisión del 30%. Si se recopila una cuenta después del inicio de una demanda por cobro, agregaremos los honorarios y gastos de abogados razonables y los costos judiciales a nuestros cargos e intereses relacionados con el tratamiento, además de la comisión de la agencia de cobro.

**Consentimiento a las revelaciones**

Si intentamos comunicarnos con usted con respecto al tratamiento o los cargos del paciente y, en su lugar, contactamos con alguien que creemos que está directamente involucrado en la atención del paciente, como su cónyuge, otro miembro de la familia o un amigo cercano, usted da su consentimiento a nuestra divulgación a esa persona de cualquier información que nuestro consultorio considere apropiada respecto al tratamiento o los cargos para el paciente Si el paciente está cubierto por el seguro, usted también da su consentimiento para la divulgación de información relacionada con el tratamiento o los cargos del paciente al titular de la póliza o persona asegurada principalmente por la póliza

X_____ Fecha Firmada :_____

Firma de la persona responsible de los cargos

Nombre del Firmante:_____ Nombre del Paciente:_____

Relacion del firmante con el paciente (si es uno misno, asi lo indique):_____

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# Authorization for Caregiver to Act for Parent or Guardian

Child's name: _____ Date of birth: _____

Child's name: _____ Date of birth: _____

Child's name: _____ Date of birth: _____

Child's name: _____ Date of birth: _____

Caregiver's name: _____ Phone: _____

Relationship of caregiver to children: _____

Caregiver S.S. #:_____ D.O.B.:_____ Address:_____

I, the undersigned parent or guardian of the children named above (or child, if just one), entrust the care of the children to the caregiver named above during any present or future visit to any office of Tebo Dental Group. The purpose of this Authorization is to permit the children to receive dental treatment when I cannot be present in person. I understand that only adults (18 or older) may act as caregivers under this Authorization.

The caregiver has the power and authority, on my behalf:

- to receive and disclose all health information, and to make all decisions, related to the dental treatment of the children at any office of Tebo Dental Group;
- to execute in my name any consent to treatment and any other consent or document relating to the exercise of the powers and authorities granted in this Authorization;
- to commit me to pay all charges for dental treatment to which the caregiver consents; and
- to perform any other act necessary or appropriate to the exercise of powers and authorities granted by this Authorization as fully as I could do if present in person.

Every act the caregiver lawfully does pursuant to this Authorization shall be binding on me. I understand that I will be liable for all charges for dental treatment to which the caregiver consents pursuant to this Authorization.

This Authorization shall remain in effect until completion of dental treatment of the child(en) at any office of Tebo Dental Group or until I revoke this Authorization as provided below.

I understand that I have the following rights: I can revoke this Authorization at any time by giving my oral or written revocation to the office of Tebo Dental Group at which my children are being treated. My revocation will not be effective for any disclosures already made or any actions already taken in reliance on this Authorization. Tebo Dental Group may not condition treatment, enrollment in any health plan or eligibility for any benefits on whether or not I sign this Authorization. I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and may no longer be protected by federal law. I have received a copy of this Authorization.

I HAVE READ AND I UNDERSTAND THIS AUTHORIZATION.

𝒳_____ Date signed: _____

*Signature of parent or guardian*

Printed name: _____ Phone: _____

# Acknowledgment of Receipt of Notice of Privacy Practices

Patient name:_____ Date of birth:_____

I have received either a paper or an electronic copy of the Notice of Privacy Practices for Tebo Dental Group. I understand that I am entitled to receive a paper copy of the Notice if I ask for it, even if I have already agreed to receive only an electronic copy.

*Please check and fill-out the following if you want to receive future notices by email:*

☐ I consent to receive any future Notice of Privacy Practices for Tebo Dental Group by email at the following email address: _____

*X*_____ Date signed:_____
*Signature of patient or personal representative*

Signed by: ☐ Patient or: ☐ Personal Representative. If signed by the patient's personal representative:

Basis of representative's authority:_____

Representative's name:_____ Phone:_____

Representative's address:_____

---

**For office use only:**

*Please complete the following only if the acknowledgment section above has not been signed by the patient or the patient's personal representative:* We made a good faith effort to obtain a written Acknowledgment of Receipt of Notice of Privacy Practices, but an acknowledgment could not be obtained because (*please check one or more as appropriate*):

☐ The patient or the patient's personal representative refused to sign.

☐ A communication barrier prevented us from obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other (please explain)_____

_____

_____

_____

_____

_____

_____

Completed by:_____ Position:_____

Staff member's initials:_____ Date completed:_____

TDG Office:_____

# Notice of Privacy Practices

*This revision is effective starting September 23, 2013. This notice supersedes all prior notices.*

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

## Who We Are

This notice describes the privacy practices of Tebo Dental Group, which includes the dental offices known as Tebo Dentistry for Kids Lilburn, Tebo Family Dentistry Lilburn, Tebo Family Dentistry Gainesville and Tebo Dentistry for Kids Dacula. These privacy practices apply to our dental practice and to our staff, including our dentists, hygienists and other health care professionals working at our offices. Some of our dentists are independent contractors and are not our employees.

## Our Commitment

We are committed to safeguarding the privacy of your health information. This notice tells you about the ways and conditions under which we may use and disclose your health information. We also describe your rights, and certain duties we have, concerning the use and disclosure of your health information. This notice applies to all of the records of your dental or other medical care generated by our dentists, hygienists and other staff members and any other health information that we may have about you.

## Our Duties

We are required by law to maintain the privacy of your health information, to give you this notice of our legal duties and privacy practices and to follow the terms of this notice (or the notice currently in effect, if this notice is revised). We also are required by law to notify you if there is a breach of security with respect to your health information. In the event of such a breach, we will notify you directly in writing or, if your contact information is out of date, we will take steps to notify you by other means, such as a posting to our web site or publishing notices in print or broadcast media.

## Change in Privacy Practices

We reserve the right to change this notice and the revised notice will be effective for health information we already have about you as well as any health information we receive in the future. If we revise this notice, we will endeavor to provide you with a revised notice electronically or in person on your next visit to one of our offices following the effective date of the revised notice. The current revision of this notice will be posted in our dental offices and on our web site and will include the effective date.

## How We May Use and Disclose Your Health Information

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we will explain what we mean and give examples where appropriate. Some uses and disclosures of your health information require your written authorization, others require that we give you an opportunity to agree or object and still others require neither your written authorization nor an opportunity for you to agree or object.

### Uses and Disclosures in the Following Categories Require Neither Your Written Authorization Nor an Opportunity for You to Agree or Object:

We may use or disclose your protected health information for the purposes described in the following categories without your written authorization and without giving you an opportunity to agree or object. In some cases, we will give you notice of the use or disclosure.

**Treatment**: We may use your health information to provide you with dental treatment or services. We may disclose your health information to dentists, dental assistants, hygienist, other dental office personnel or other health care providers who are involved in your treatment or care. For example, your dentist may need to disclose some of your health information to order tests or lab work to be performed at an outside laboratory or other outside health care provider.

**Payment**: We may use and disclose health information about your treatment and services to bill and collect from you, your insurance company or another third party payer. For example, we may need to give your health insurance plan information so that it will pay us or reimburse you for dental services. We may also tell your health insurance plan about a treatment you are going to receive to determine whether your plan will cover it.

**Health Care Operations**: We may use and disclose health information about you for office operations. These uses and disclosures are necessary to run our dental office and help to provide you with appropriate dental services. For example, we may use your health information to review our treatment and services and to evaluate the performance of our staff in caring for you. Some of these reviews may be conducted by independent dentists who are members of our staff, but are not employees of the office. We may also combine health information about many of our patients to decide what additional services we should offer and what services are not needed. We also may disclose information to dentists, hygienists, dental assistants and other office personnel for review and learning purposes.

**Required By Law**: We will disclose health information about you when required to do so by federal, state or local law, except that federal law takes precedence if there is a conflict with state or local law.

**Public Health Activities**: We may disclose your health information for public health activities. These activities generally include prevention or control of disease, injury or disability, reporting births and deaths, reporting child abuse or neglect, reporting reactions to medications or problems with products, notifying people of recalls of products they may be using or notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**Victims of Abuse, Neglect or Domestic Violence**: If we believe you have been the victim of abuse, neglect or domestic violence, we will disclose your health information to the appropriate government authority to the extent required by law. Even if not required by law, we may disclose such information if you agree to the disclosure; if we believe, in the exercise of professional judgment, that disclosure is necessary to prevent serious harm to you or other potential victims; or if you are unable to agree because of incapacity and a law enforcement or other public official authorized to receive the report represents that your health information is not intended to be used against you and that an immediate enforcement activity that depends upon the disclosure would be adversely affected by waiting until you agree to the disclosure.

**Health Oversight Activities**: We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary 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 health information in response to a court or administrative order. We also may disclose your health information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain a court order protecting the information requested.

**Law Enforcement**: We may disclose health information if asked to do so by a court order, subpoena, warrant, summons or similar process for law enforcement purposes or by a law enforcement official to identify or locate a suspect, fugitive, material witness or missing person or to gather information about someone who is suspected to be the victim of a crime, about a death we believe may be the result of criminal conduct or about criminal conduct that occurs on our office premises.

**Coroners, Medical Examiners and Funeral Directors**: We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may disclose health information about patients of the practice to funeral directors as necessary to carry out their duties.

**Organ Donation**: We may disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

**Research Purposes**: We may use or disclose your health information for a research purpose, but only if we observe a variety of conditions intended to safeguard the privacy of your health information. The practice does not anticipate that it will use or disclose your health information for a research purpose.

**Averting a Serious Threat to Health or Safety**: We may use or disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

**Military and Veterans**: If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

**National Security and Intelligence Activities**: We may disclose your health information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

**Protective Services for the President and Others**: We may disclose your health information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or so that they may conduct special investigations.

**Inmates**: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official if the release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others or for the safety and security of the correctional institution.

**Workers' Compensation**: We may disclose your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Limited Data Set**: We may use or disclose your health information in a "limited data set", which means that certain identifying information (like name, address, phone number, etc.) is deleted and the reduced information is shared with another party, but only for purposes of research, public health or health care operations and only in compliance with federal privacy regulations.

**Fundraising**: We may use or disclose your health information for our own fundraising activities, but the type and amount of information we may use for such purpose is limited significantly by federal privacy regulations, unless we get your prior written authorization to use or disclose additional information. We do not have any present intention of sending you any fundraising communications, but if we ever send you any such communications, we will give you the opportunity to opt-out of receiving any further communications from us concerning fundraising.

**Uses and Disclosures in the Following Categories Require That You Have an Opportunity to Agree or Object:**

For the use or disclosure of your health information in the following categories, we do not need to get your prior written authorization, but we do need to give you an opportunity to agree or object.

**Patient Directory**: The practice currently does not maintain a directory of patients. If the practice creates such a directory, we will give you an opportunity to restrict some or all of your information from appearing in the directory.

**Persons Involved in Your Care or Payment for Your Care**: We may disclose your health information to a member of your family, a friend or another patient if the family member, friend or other patient is directly involved in the your care and the disclosure is necessary for your welfare. The practice will limit the health information disclosed to the family member, friend or other patient to health-related symptoms and to information designed to help you deal with your condition or treatment, including setting and changing appointments, receiving instructions for post-visit care or picking up treatment-related items. We may also disclose a limited amount of your health information to locate you or to locate or notify your family member or friend. We will not make these disclosures to your friends and family if you tell us not to do so.

**Immunization Information for School**: We may disclose proof of immunization to a school where you are a student or prospective student if the school is required by Georgia or other law to have such proof of immunization prior to admitting you to school and you agree to the disclosure. If we are required by law to disclose such proof of immunization, then we must do so whether or not you agree to the disclosure.

**Uses and Disclosures in the Following Categories Require Your Prior Written Authorization:**

For the use or disclosure of your health information in the following categories, we must get your prior written authorization.

**Psychotherapy Notes**: Without your prior authorization, we are not allowed to use or disclose any psychotherapy notes that may be part of your health information except to defend ourselves in a legal action or other proceeding.

**Marketing**: Without your prior authorization, we are not allowed to use or disclose your health information for marketing purposes unless we are communicating with you face-to-face or we are providing you with a promotional gift of nominal value. It is not considered marketing, however, if we are telling you about possible treatment options or alternatives that we think may be of interest to you. If our marketing activity involves financial remuneration to us from a third party, the patient authorization will state that such remuneration is involved.

**Sale of Health Information**: Without your prior authorization, we are not allowed to sell your health information, except that selling does not include use or disclosure of health information for the purpose of research, public health, treatment, payment, the sale of our practice, business associate services to us, providing you with information when you request it, complying with law or for any other purpose where we are only

recovering our cost in preparing and transmitting your health information or are only charging a fee authorized by law. If we propose to sell your health information, the authorization will state that the sale will result in financial remuneration to us from a third party.

**Any Use and Disclosure Not Covered in this Notice**: Uses and disclosures of health information in the three categories immediately above this paragraph, and any other uses or disclosures not covered anywhere else in this notice, will be made only with your prior written authorization. You will have the right to revoke that authorization at any time orally or in writing. If you revoke your authorization, we will no longer use or disclose your health information to the extent your authorization is needed for the use or disclosure. We are unable, of course, to take back any uses or disclosures we have already made with your authorization. Also, we are required in any event to retain our records of the care that we provide to you.

### Disclosure to or Use by Business Associates:

There are some services that we provide through contracts with business associates. For example, we use an outside copy service if needed to make copies of your x-rays. When these services are contracted, we may disclose your health care information to our business associate so that the associate can perform the job we have asked the associate to do. To protect your health information, we require our business associates to commit to us in writing that they will safeguard the privacy of your health information to the same extent that we are required to safeguard it, with only very limited exceptions permitted by federal privacy regulations.

## Your Health Information Rights

You have the following rights concerning health information we have about you:

**Right to Request Privacy Protection:** You have the right to request a restriction or limitation on the health information about you that we use or disclose for treatment, payment or health care operations. We are not required to agree to such a request unless the disclosure you wish to restrict is to a health plan for the purpose of carrying out payment or health care operations (and is not for the purpose of carrying out treatment) and the health information to be restricted pertains solely to a health care item or service for which you have paid us out of pocket in full. If we do agree to your request, the requested restriction will not be effective until you receive written confirmation from us that we have agreed to the request. In emergency treatment situations, agreements to restrict the use or disclosure of your health information will not apply. To request restrictions, you should contact the privacy officer at the address or number listed at the end of this notice to get the form you will need to fill out for this purpose. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both and to whom you want the limits to apply (for example, your children, your parents or others involved in your care). To be binding on us, any agreement to comply with special restrictions must be in writing signed by the privacy officer or another authorized employee of our practice.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about your health information in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the privacy officer listed at the end of this notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to Inspect and Copy:** You have the right to inspect and to receive a copy, summary or explanation of your health information. You can also designate a third party to receive the information on your behalf. If you want to inspect or receive a copy, summary or explanation of your health information, please contact the privacy officer listed at the end of this notice to obtain and complete the required form. All requests must be made in writing. If you request a copy of your health information, we may charge a fee for the costs of copying and mailing your request or of preparing a written summary or explanation. If you request an electronic copy of health information that we maintain in electronic form, we will provide the information in electronic form to you or directly to a third party of your choice. For providing an electronic copy of your health information, we will charge you only our labor costs in responding to your request. We may deny your request in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Ask for Changes**: If you believe that health information we have about you is incorrect or incomplete, you may ask us to change or add to the information. You have the right to ask for a change or addition for as long as the information is kept by the office. You should contact the privacy officer listed at the end of this notice to get the required form. All requests for changes or additions to your health information must be made in writing. You must give us a reason for your request. We may deny your request if it is does not

include an appropriate reason to support the request. In addition, we may deny your request if you ask us to change or add to information that we did not create (unless the person or entity that created the information is no longer available to make the change or addition), information that is not part of the health information kept by the office, information that is not part of the information which you would be permitted to inspect and copy or information that is already accurate and complete.

**Right to an Accounting of Disclosures:** You have the right to request an accounting of certain disclosures of your health information made by us or our business associates. We are not required to account for disclosures in the following categories: disclosures made to carry out treatment, payment or health care operations, disclosures to you, disclosures made pursuant to your authorizations, disclosures to persons involved in your care and certain other special disclosures described in federal privacy regulations. To ask for a list of disclosures that we are required to report, you should contact the privacy officer listed at the end of this notice to get the form you will need to fill out for this purpose. Your request must be in writing and state a time period no longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

**Right to a Paper Copy of this Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact the privacy officer listed at the end of this notice or ask any of our staff members.

## Complaints

If you believe your privacy rights have been violated at any of our offices or by any of our staff members or business associates, you may file a complaint with our dental practice or with the Secretary of the Department of Health and Human Services. To file a complaint, contact the privacy officer listed at the end of this notice or ask any of our staff members. All complaints must be submitted in writing. We will not retaliate against you or penalize you in any way for filing a complaint.

## Contact Information

Tebo Dental Group, Privacy Officer, phone: 770-925-3300, mailing address: P.O. Box 1953 Lilburn, Georgia 30048-1953.

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