

# WELCOME

## Patient Information

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

E-mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex ☐ M ☐ F Birthdate \_\_\_\_\_ Age \_\_\_\_\_

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Dental Insurance

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Please print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## Phone Numbers

Phone (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Alt. Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Work (\_\_\_\_\_) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

## Dental History

Reason for today's visit _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____



## Health History

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you wear contact lenses? ☐ Yes ☐ No

### Women:

Are you pregnant? ☐ Yes ☐ No Due date \_\_\_\_\_ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

### Medications

List any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

### Allergies

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

### Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

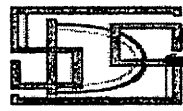
Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_



**Significance Dental Specialists**  
Periodontics Orthodontics Endodontics

## **DIAGNOSIS: PERIODONTAL DISEASE (GUM DISEASE)**

I have informed I have periodontal disease that could lead to the loss of teeth. I have been advised of the proposed therapies and attempt to extend the life expectancy of my teeth. This consent form outlines the treatment program, its expected consequences and limitations. Dr. Huang has discussed with me the nature of periodontal disease, it's severity, and the possible continued deterioration of my gum condition leading to loss of teeth. He has also discussed with me the following:

1. Oral hygiene instruction; disease prevention.
2. The administration of local anesthetic (topical/inject)
3. Scaling/root planning (deep cleaning under gum line)
4. The possible necessity of periodontal surgery to include treatment of both gum and bone supporting structures with placement of bone grafts, soft tissue grafts, and special membranes for guided tissue regeneration.
5. Extraction of teeth or roots as determined during surgical treatment.
6. Periodontal maintenance therapy which would include daily home care, periodontal prophylaxes, and possibly periodontic root planning procedure and/or re-treatment.

## **ALTERNATIVES**

I have been informed of the possible alternatives to the above treatment to include:

1. Maintenance therapy only with the general dentist.
  2. Scaling and root planning and maintenance therapy only.
  3. Extraction
  4. Other \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## **TREATMENT RISKS**

The risks to treatment include but are not limited to: bleeding, discomfort, or pain, nerve damage either transient or permanent, infection facial or intra-oral, failure to achieve the desired result, the need for further treatment or re-treatment, complications of medication or sedation if applicable, damage to existing dental restoration, the need for placement or replacement of dental restorations, change in shape or appearance of the teeth and gum tissue, tooth and gum sensitivity, alteration of certain speech sounds.

## **NON-TREATMENT RISKS**

I understand that if no treatment is rendered the risks to my dental health include (but are not limited to) the following: premature loss of the tooth or teeth involved, gum recession, halitosis, loosening of the teeth, abscess (gum boils), tooth drifting, flaring or other tooth movement, and the deepening of periodontal and/puss pockets.

## **CONSENT OF UNFORESEEN CONDITIONS**

If any unforeseen conditions should arise in the course of treatment, either surgical or non surgical, calling for the doctor's judgment for procedures in addition to or different from those contemplated, I further request and authorize the doctor to do what ever he may deem advisable.

## **NO WARRANTY**

No guarantee, warranty, or assurances have been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to the individual patient differences a risk of failure, relapse, or worsening of my present periodontal condition may result despite treatment and may require a treatment and/or extraction of the involved teeth. However, it is the doctor's opinion that therapy would be helpful and that any further loss of supporting tissue or bone would occur sooner without the recommended treatment.

## **OUR POLICY AS TO INSURANCE**

Insurance coverage is a contract between you and your insurance company not our office. We will pre-authorize your treatment; however, pre-authorization is never a guarantee of payment and the ultimate responsibility of payment for your treatment belongs to you. It is your responsibility to be aware of your plan's coverage as to frequency limits and calendar year maximums. Payment is expected at the time service is rendered.

**I CERTIFY THAT I HAVE READ FULLY AND HAVE HAD ALL MY QUESTIONS ANSWERED SO THAT I UNDERSTAND THE ABOVE CONSENT TO TREATMENT.**

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Signature of Patient or Guardian

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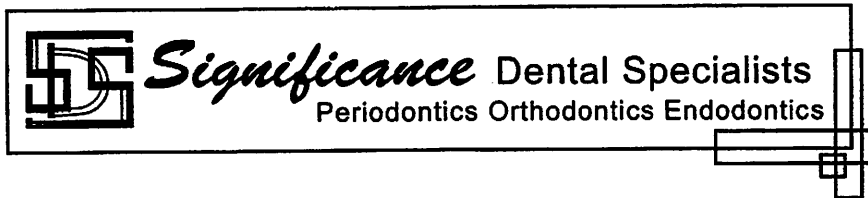
Date

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Witness

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Date



## Office Policies

(Please read carefully and initial each section)

### Payments

Payments are due at the time of service. If payment needs to be spread out, 3<sup>rd</sup> party dental plan can be applied via Chase or Care Credit, our staff can help you with the application. For your convenience, in addition to cash and checks, we accept Visa, MasterCard, and Discover Cards. Alternative payment methods are available upon inquiry. To ensure proper scheduling, deposits and payments are to be made as follows: **\$50 deposit must be made for every quadrant of scale/root planning; 50% of all implant procedures and all initial responsibility must be made prior to the scheduled date.** The remaining balance will be collected via insurance payments or at the date of service. If you have any credits, a refund will be issued in two to three weeks.

### Insurance

Unfortunately, there is a great deal of confusion about dental insurance. Please remember that we do not work for any insurance company or for any PPO or HMO. **We work for you.** Our treatment recommendations are based solely on our professional knowledge of what will give you the best outcome. Insurance companies' treatment recommendations are based solely on what is best for their profit margins. While we are not directly involved with any insurance company, we will do all we can to help you receive maximum benefits from your insurance plan. For new patient consultations and dental cleanings, we provide "attending doctor" statements for you to attach to your insurance claim form. For more extensive treatment we will submit a pre-treatment estimate to your insurance company, when requested, to determine what reimbursement is available for anticipated services. After that treatment is completed, our office will then send in a final insurance claim. We will follow up with the insurance company and re bill if necessary. However, **if we don't get paid in 90 days from the date of service, the balance will be your responsibility and payment is expected within 30 days of statement date unless other arrangements are made. There will be a 3% or \$10 monthly finance charge incurred whichever is higher on any balances past 30 days. If account is turned over for collections, there will be a \$25.00 collection service fee added to account balance.** You can then make arrangements for the insurance company to pay you back directly. We have a staff member whose sole job is to help patients receive as much as possible from their insurance company, but remember this is done as a courtesy to our patients. Each patient is entirely responsible for his or her bill.

### Cancellations

We understand that on occasion cancellations are necessary, particularly due to illness. Please remember, though, that each appointment time is reserved exclusively for that individual patient, and without adequate time to fill the broken appointment, the operatory is empty. Therefore, if we are unable to have **two full business days notice of a cancellation, an overhead charge of \$50 per hour, for each broken root planning appointment and \$200 per hour for each procedure appointment with the doctor,** unless we are able to fill that time. We would much prefer never to make that charge, so try to schedule a time most convenient for you.

I, \_\_\_\_\_, have read and understand office and cancellation fee policies.  
Please Print Name

\_\_\_\_\_  
Signature Patient or Guardian

\_\_\_\_\_  
Date



**Significance** Dental Specialists  
Periodontics Orthodontics Endodontics

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*\* You May Refuse to Sign This Acknowledgement\**

I, \_\_\_\_\_, have received a  
copy of this office's Notice of Privacy Practices

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

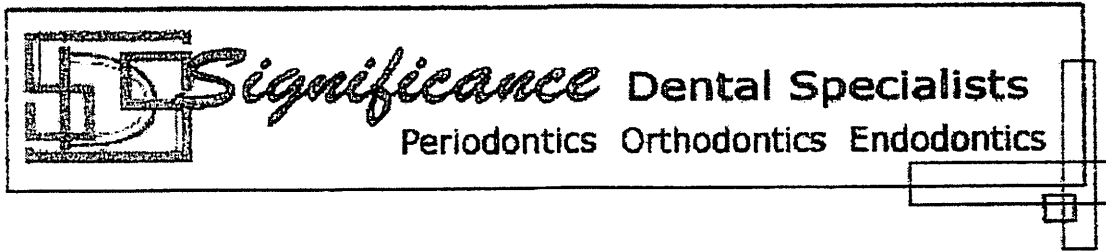
### For Office Use Only

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





## NOTICE OF PRIVACY PRACTICES

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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.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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### 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, 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. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**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.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient 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.

**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, your general condition, or death. 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, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

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

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**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 of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

## **PATIENT RIGHTS**

**Access:** You have the right to look at 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 must 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. If you request copies, we will charge you \$\_\_\_ for each page, \$\_\_\_ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative 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 and certain other activities, for the last 6 years, but not before 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 that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} 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.

**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.