

PATIENT REGISTRATION

ID: _____

Chart ID: _____

First Name: _____

Last Name: _____

Middle Initial: _____

Patient Is: Policy Holder Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____

Last Name: _____

Middle Initial: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Birth Date: _____

Soc Sec: _____

Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient

Primary Insurance Policy Holder

Secondary Insurance Policy Holder

Patient Information

Address: _____

Address 2: _____

City: _____

State / Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Sex: Male Female

Marital Status: Married Single

Divorced Separated Widowed

Birth Date: _____

Age: _____

Soc Sec: _____

Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____

Prof. Dentist: _____

Employer ID: _____

Prof. Pharmacy: _____

Carrier ID: _____

Prof. Hyg: _____

Emergency Contact

Emergency Contact #

Other Parent's Name

Other Parent's #

Physician Name

Chief Complaint

Last Dental Visit

Primary Insurance Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____

Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____

Rem. Deduct: _____



Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name of Primary Care Physician and date of last physical _____

Have you ever been hospitalized or had a major operation? Yes No _____

Have you ever had a serious head or neck injury? Yes No _____

Are you taking any medications, pills, or drugs? Yes No _____

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

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____

Have you ever had Botox or Dermal Fillers? Yes No _____

Have you ever had any other elective facial cosmetic procedures and/or laser treatments? Yes No _____

Have you ever been diagnosed with Sleep Apnea or had a Sleep Study or testing done? Yes No _____

Have you ever had Orthodontic treatment? Type, Length of treatment, How long ago? Yes No _____

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No _____

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking Oral contraceptives

Are you allergic to any of the following?

Aspirin/Ibuprofen Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Do you have, or have you had, any of the following?

AIDS/HIV positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/ Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy/ Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/ Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/ Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/ Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/ Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/ Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No

Patient Signature _____

Date _____

Please read through and answer the following:

How often do you brush? _____ Do you use a manual or electric toothbrush? _____

How often are you flossing? _____ Do you use a mouth rinse? _____

On a scale from 1 – 10 (1 being the worst and 10 the best), how do you rate your home care? _____

Last dental examination: _____ Last dental cleaning: _____

Chief complaint or main reason for dental visit today:

New Patient Cleaning Broken Tooth (area: UR UL LL LR) Consult: _____

Other: _____

Please circle the following that apply to you:

HEAD

Frequent headaches Migraines Tension Headaches

Fatigue/fogginess Tinnitus Dizziness/ Vertigo

NECK/BACK

Upper back pain Fibromyalgia Joint pain

Limited range of motion Muscle Atrophy Muscle pain

THROAT

Difficulty breathing through nose Choking/shortness of breath Snoring/ Breathe loud

JAW

Jaw/TMJ Pain Jaw Popping/Clicking Clenching/Grinding

Locked In/Restricted bite Jaw/chin too strong/weak Limited jaw movement

MOUTH

Gummy smile Small lips Large nasolabial folds

Too broad smile Too Narrow smile Chronic bad breath

GUMS

Bleeding after brushing Bleeding after flossing Black triangles

Receding gums Swollen/ puffy Sore/ hurt

TEETH

Yellow/ Dark teeth Spaces or Gaps/ Pack food Crooked/ Uneven

Notching near gums Sensitive to hot/cold Too Short/ Worn down

Misshapen/ Not centered Buck teeth/ Stick out Too Long/ Horsey teeth

Missing teeth Concerned about silver fillings Discoloration/Calcification



ADVANCED
DENTAL ARTS NW
Russell C. Teasdale DMD

FINANCIAL POLICY AND AGREEMENT

Few things affect the quality of life as much as the comfort and confidence of comprehensive dental care. At ADANW, we are confident we provide a great value for our patients, providing personalized and high quality and high tech services, not only from Dr. Teasdale, but also from every member of our team. And although we will work with you always to obtain your greatest benefit from your dental insurance, or HSA/FSA accounts, we are not a financial institution and cannot guarantee insurance benefits and insurance payments. We appreciate that people have differing needs in fulfilling their financial obligations, and to help out, we offer the following payment options:

WE REQUIRE PAYMENT IN FULL ON DATE OF SERVICE FOR DENTAL TREATMENT. We can extend a 5% courtesy savings for payment in full by cash or check, for services of \$500 or more.

WE ACCEPT: American Express, Discover, Master Card, Visa, Care Credit, Cash, and Check.

PRE-PAYMENT PLAN: Much like a Lay-Away Plan, we accept whatever payments you feel comfortable with, and can begin treatment as soon as it is fully funded.

CARE CREDIT PAYMENT OPTIONS: If you are not able to pay in full on the date of service, then we can assist you in applying for the Care Credit payment option. It does require pre-approval, and has a great, **same as cash, no interest financing option** available. No Additional “payment in full” discounts apply when using Care Credit. We offer 6 month with 0% interest for amounts over \$200. 12 month with 0% is only offered for Invisalign and Orthodontic services.

FOR SERVICES OVER \$2000: For services in excess of \$2000, we request **half paid prior** to the appointment, to reserve time for you. All this will apply 100% toward your final bill. Balance will be due at the time of service.

PATIENTS WITH DENTAL INSURANCE: We welcome your dental insurance if it is an “open option”, and we will work with you to obtain your full benefit for our services. Please understand that you, through your employer, have a contract with that insurance carrier, and ADANW is not a party to that agreement. As such, it is not possible to predict *exactly* what each policy pays, although we always strive to be accurate. Because of this, it is important that you recognize that you are ultimately responsible for the full balance, and we will issue you a refund check once the insurance has assisted you with their final payment.

ADANW RESERVES THE RIGHT TO THE FOLLOWING: We can charge \$35 for any returned checks. If a patient changes their mind about treatment, we will charge for any incurred lab fees and any doctor chair time. Refunds are done once a month. If a patient chooses to leave the practice, we will forward a copy of your dental records to you or to your new dentist upon receiving your signed, written request.

48 HOUR CANCELLATION AND NO SHOW: ADANW does call, text, and email to confirm your appointment. If you cannot make an appointment as scheduled, please notify the office. There will be a charge of \$50 per 60 minutes of scheduled time for a broken appointment or cancellation with 2 business days’ notice for your appointment. If you have no shown/or last minute cancelled more than 2 times this will result in a non-refundable deposit for the appointment of \$50 per 60 minutes.

I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY AND AGREEMENT

Signature

Date



ADVANCED
DENTAL ARTS NW
Russell C. Teasdale DMD

Photo and Model Release Letter

At ADANW we like to document all types of services we do here. New patient exams start with a series of photographs for a baseline record that we can always refer back to. When coming in for treatment we like to take before and after photos to show you and to add to your records.

For valuable consideration received, I, _____ hereby give Dr. Russell Teasdale the absolute and irrevocable right and permission, with respect to the photographs that have been taken of me to be used in the following ways and republished for any commercial use for the territory of the whole world: (please choose the following)

- Intraoral Only (inside the mouth, usually before and afters of filling or crowns replacements)**
- Extraoral Only (full face photos, usually for full mouth reconstructions)**
- Both (intraoral and extraoral photos)**

- A. To copyright the same in its own name or any other name that Dr. Russell Teasdale may choose.
- B. To use, re-use, publish and re-publish the same in whole or in part, individually or in conjunction with other photographs, in any medium and for any purpose whatsoever, including (but not by the way of limitation) illustration, promotion and advertising and trade through December 31, 2009.

This authorization and release shall also apply to the benefit of the legal representatives, licensees and assigns of Dr. Russell Teasdale and Advanced Dental Arts NW.

I am over the age of eighteen. I have read the foregoing and fully understand the terms of this release.

- None of the Above, Please do not use any of my photos for “Before and After” photos.**

Signed: _____

Date: _____



1316 SW 13TH AVENUE

PORTLAND, OR 97201

(503) 235-0555

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

SIGNATURE

Please Note: It is your right to refuse to sign this acknowledgement.

For Office Use Only

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

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

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All Rights Reserved. Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

ADVANCED DENTAL ARTS NW

RUSSELL C. TEASDALE, D.M.D.

1316 SW 13TH AVENUE, PORTLAND, OR 97201
(503) 235-0555

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

You can authorize ADANW to discuss information to certain individuals. This gives us permission to discuss any insurance and account related issues as well as taking payments from partners and spouses.

Name and Relationship of Authorized Persons:

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

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

Personal Representative's Name & Relationship*

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Advanced Dental Arts NW

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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 (09/23/13), 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 official's 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 \$ 25 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.

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 Officer: Dr. Russell Teasdale

Telephone: 503-235-0555 Fax: 503-224-5726

E-mail: adanw@advanceddentalartsnw.com

Address: 1316 SW 13th Ave., Portland, Oregon 97201

