WELCOME TO JEFFREY S. SOBECKS, DDS

Today's Date: _____

Thank you for joining our family of patients and friends. Our goal is to provide excellent comprehensive dental care to patients in a friendly compassionate environment. We are dedicated to educating and guiding our patients toward making good decisions regarding their dental health and are committed to continuing our professional education to stay current with the latest advances in dentistry.
Please complete this form so that we can provide you the best possible care.

DR. JEFFREY SOBECKS

ABOUT YOU

Name: _____ ☐ Female ☐ Male

If Child – Parent/Guardians' Names: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Birthdate: ____/____/____ Age: _____ Marital Status: ☐ Single ☐ Married ☐Divorced

Email Address: _____ Social Security Number: _____

Occupation? _____ Who is responsible for this account? _____

Other family members at this practice? _____

EMERGENCY INFORMATION

Person to contact: _____ Relationship: _____ Phone: _____

HOW DID YOU FIND US?

☐ Insurance Company ☐ Website ☐ Sign on Building ☐ Referral – Who can we thank? _____

DENTAL INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Address: _____Phone: _____

Name of Policy Holder: _____ Policy Holder's birth date: ____/____/____

Relationship of policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Policy Holder's ID/social security #: _____ Group #: _____

Policy Holder's employer: _____ Employer's address: _____

Name of Secondary Insurance Company: _____ _____

Address: _____Phone: _____

Name of Policy Holder: _____ Policy Holder's birth date: ____/____/____

Relationship of policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Policy Holder's ID/social security #: _____ Group #: _____

Policy Holder's employer: _____ Employer's address: _____

MEDICAL & DENTAL HISTORY

Patient Name: _____ **Birthdate:** ____/____/____

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 may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Have you been under a physician's care in the past two years?	☐ Yes ☐ No	If yes, _____
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes, _____
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes, _____
Are you taking any medications, supplements or vitamins?	☐ Yes ☐ No	If yes, _____
Do you take blood thinners? Aspirin?	☐ Yes ☐ No	If yes, _____
Have you ever taken Phen-Fen, Redux, Fosamax, Boniva, Actonel or any medications containing bisphosphonates?	☐ Yes ☐ No	If yes, _____
Have you ever had an allergic or adverse reaction to any medication?	☐ Yes ☐ No	If yes, _____
Do you have a latex sensitivity?	☐ Yes ☐ No	If yes, _____
Are you on a special diet?	☐ Yes ☐ No	If yes, _____
Do you use tobacco?	☐ Yes ☐ No	If yes, _____
Women: Are you pregnant? Trying to get pregnant? Nursing?	☐ Yes ☐ No	If yes, _____

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

AIDS/HIV Positive	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Alzheimer's/Dementia	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Arthritis/Gout/Rheumatism	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Hearing Impairment/Hearing Aids?	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease/Pacemaker/MVP	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Disease/Hemophilia	☐ Yes ☐ No	Heart Murmur/Irregular Beat	☐ Yes ☐ No	Thyroid Problem	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Hepatitis A, B or C	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Cancer / Leukemia	☐ Yes ☐ No	Kidney Problems/Dialysis	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Other: _____	
Cold Sores/Fever Blisters	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	_____	
Diabetes	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No		

Comments: _____

If New Patient, Date of Last Exam: _____ **Date of Last X-Rays:** _____ **Dental Concerns?** _____

Reason for visit today: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. Should further information be needed you have my permission to as the respective heath care provider or agency, who may release such information to you. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ **Date:** ____/____/____

FINANCIAL GUIDELINES

At Jeffrey S. Sobecks, DDS we are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

INSURANCE

We accept most major dental insurance payments, however, we may not be an in network provider for your plan. If we are not an in network provider, review your plan details as reimbursement may vary.

- **No estimate is a guarantee of payment.** I understand that I am responsible for all charges not paid by my insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, I would be responsible for the difference.
- **Workers compensation claims** can be filed for you. Please understand the carrier will assign a dollar amount that will be paid toward the claim, which may or may not cover the entire fee. I understand that any amount not covered by the carrier will be my responsibility.
- **Minors must be accompanied by a parent or legal guardian.** If parents are separated or divorced, I understand that the person accompanying the minor will be responsible for copayment at the time of service.

PAYMENTS

Patient portion and dental lab bills are due at the time services are rendered unless **prior** financial arrangements have been made.

Payment Options

- All major credit cards are accepted (Visa, MasterCard, Discover)
- Financing option available with CareCredit

☐ **I understand all accounts over 90 days are past due and that past due accounts are subject to 1.5% finance charge.**

Temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

CANCELLATION POLICY

I understand that I need to give 24 hours' notice if I am unable to keep my reserved appointment. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.

☐ **I understand missed appointments and appointments cancelled with less than 24 hours' notice are subject to a $25 fee.**

By signing below, I acknowledge I have read and understand the guidelines above.

Signature of Patient, Parent or Guardian: _____ Date: ____/____/____

PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms of which my personal health and identification information may be used.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name of Patient: _____

Name of Parent or Guardian: _____

Signature of Patient, Parent or Guardian: _____ **Date:** ____/____/____

☐ I give permission for the following communications to be used by Jeffrey S. Sobecks, DDS (please check all that apply):

☐ Cell Phone
☐ Home Phone
☐ Text Messages Permitted
☐ Work Phone
☐ eMail

☐ I am granting permission for Jeffrey S. Sobecks, DDS to disclose their identity to anyone who may answer my home, work or cell phone.

☐ I am granting permission for Jeffrey S. Sobecks, DDS to leave a message with any person who may answer my home, work or cell phone.

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ Patient refused to sign
☐ Communication barriers
☐ Emergency situation
☐ Other: _____

INFORMED CONSENT

RISKS AND BENEFITS OF DENTAL PROCEDURES

It is important to us that our patients at Jeffrey S. Sobecks, DDS have knowledge of risks and benefits of dental procedures. Whenever possible, we will show you photographs and/or x-rays to illustrate dental problems and will fully explain proposed treatment plans. In the course of treatment, we may need to modify your treatment plan to address problems that could not have been diagnosed in the clinical exam alone or by preoperative x-rays. If/when this occurs, we will explain our findings and show you diagnostic photographs whenever possible. We ask that you review the procedures listed and encourage you to ask any questions you may have.

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

Dental Prophylaxis (Cleaning): I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.

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

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

Drugs and Medication: I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction.) I have informed Dentist of any known allergies. Anesthetic, medication and drugs may cause drowsiness, lack of awareness, and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of anesthetic, medication and drugs that may have been prescribed to me for my care. Risk of local anesthesia may include temporary or permanent numbness or bruising. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my Dentist of all medications that I am currently taking.

Fillings: I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand sensitivity is a common after effect of a newly placed filling.

Removal of Teeth: Alternatives will be explained to you (root canal therapy, crowns, and periodontal surgery, etc.) I understand the removal of teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. Some of the risks are pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months), exposed sinuses, or fractured jaw. I understand that bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

Crown, Bridges, Veneers and Bonding: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I understand that the final opportunity to make changes to a new crown, or bridge (including shape, fit, size, or color) must be done prior to cementation of final restoration. I understand that that in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or permanent bite problems. This may necessitate a remake of the crown, bridge or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

Dentures – Complete or Partial: I understand that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing those appliances may include looseness, soreness and possible breakage. I understand the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures frequently require several adjustments and relines. A permanent reline or second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there may be additional charges.

Endodontic Treatment (Root Canal): I understand that there is no guarantee that root canal treatment will save a tooth. Complications can occur from the treatment and occasionally canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

Periodontal Loss (Tissue & Bone): I understand that this is a serious condition, causing gum and bone infection or loss and can lead to the loss of teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor). Treatment may involve the participation of an oral surgeon. Fees for his/her services are separate from our service fees. Alternative treatment will be explained to you (gum surgery, antibiotic/antimicrobial treatment, replacements, and/or extractions). I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours. Should bleeding persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

Implants: Implants are alternatives to bridge, partials or dentures. I understand that no dentistry is permanent and that ideal implant placement may not be possible based on anatomic limitations. This treatment may require the participation of an oral surgeon or periodontist. Fees for his/her services are separate from our service fees. I have been informed that there is always the possibility of failure resulting from the tissues of the body not physiologically accepting these artificial device, and that infections may occur post operatively which may necessitate removal of the affected implant(s). I realize there is the slight possibility of injury to the nerves of the face and tissues of the oral cavity, and this numbness may be of a temporary or, rarely, permanent in nature. I understand that is absolutely necessary with implant therapy to have regular periodic examinations and cleanings. I agree to assume the responsibility to make appointments and report as instructed by the treating dentist.

Sedative Fillings: Sedative fillings are temporarily. They are placed if near caries exposure of the nerve is suspected. If the tooth becomes symptomatic after 4-6 weeks, it is likely the tooth will need a root canal or it may need to be extracted. If the tooth is asymptomatic after 4-6 weeks, then the root has not been exposed. The sedative filling allows the tooth to lay down reparative dentin and will enable the Doctor to remove the decay and restore the tooth. I understand that any time a restoration is performed there is a possibility of trauma to the nerve of the tooth, which could result in varying degrees of sensitivity and complications including but not limited to the following: cold sensitivity, hot sensitivity, biting sensitivity, abscess, pulp necrosis. Most of the symptoms usually resolve as the nerve heals. Complications may arise resulting in the need for additional treatment. This may include one or more bite adjustments, replacement of the restoration due to open margins discovered after final cementation, root canal treatment or tooth removal.

Bleaching: Bleaching is a procedure done either in office or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea, tobacco, red wine and other colored beverages will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and /or gum inflammation, which may subside when treatment is discontinued. The Dentist may prescribe fluoride treatments to aid with sensitivity. Caramide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I have carefully read above conformed consent and fully understand all risks as it relates to my case.

Name of Patient: _____ **Name of Parent or Guardian:** _____

Signature of Patient, Parent or Guardian: _____ **Date:** ____/____/____

NOTICE OF PRIVACY PRACTICES / YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBLITIES

This notice describes how medical information about you may be used and disclosed at the office or Jeffrey S. Sobecks, DDS and how you can get access to this information. If you have any questions or concerns, you may contact us at:

Jeffrey S. Sobecks, DDS
6325 York Road, Suite 302
Parma Heights, OH 44130
440.888.5591 sobecksdds@gmail.com

YOUR RIGHTS

You have the right to:

- Get a copy of your paper or electronic dental record
- Correct your paper or electronic dental record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide mental health care
- Market our services

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Treat you
- Run our practice
- Bill for your services
- Help with public health and safety issues
- Do research and education
- Comply with the law
- Work with a medical examiner or funeral director
- Respond to lawsuits and legal actions
- Address worker's compensation, law enforcement, & other government requests

EXPLANATION OF YOUR RIGHTS

- **Get an electronic or paper copy of your dental record:** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your dental record:** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **Ask us to limit what we use or share:** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we've shared information:** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice:** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated:** You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

EXPLANATION OF YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We never share your information unless you give us written permission.

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways.
Treat you: We can use your health information and share it with other professionals who are treating you. *Example: Dr. Sobecks may consult a specialist regarding your case or ask another doctor about your overall health condition.*
Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues: We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research. Occasionally we present case studies to other dental professionals. Patients are never identified by name. They are referred to as "The Patient".
Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions We can share health information about you in response to a court or administrative order, or in response to a subpoena.

EXPLANATION OF OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our office.