FORTUNE SMILES DENTAL

Patient Registration Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Email: Today's Date (mm/dd/yyyy):

Preferred Name: ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

How did you find out about us? ☐ Patient ☐ Website ☐ Marketing ☐ Walk-in ☐ Staff Other: _____

Name: Last First Middle Initial

Home Phone: *include area code* ( )

Cell Phone: *include area code* ( )

Address: Mailing address

City: State: Zip:

SS#: Date of Birth (mm/dd/yyyy):

Employer: Business Phone: *include area code* ( )

Emergency Contact: Relationship: Home Phone: *include area code* ( ) Cell Phone: *include area code* ( )

College Student Status: ☐ Full Time ☐ Part Time ☐ Please provide school info: School Name: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Address: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed Address 2: _____

Pref. Pharmacy: Phone: ( ) City, State, Zip: _____

Dental Insurance Information

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: _____ Insured Birth Date (mm/dd/yyyy): _____

Employer: _____ Ins. Company: _____

Address of Policy Holder: _____ Address: _____

Address Line 2: _____ City, State, Zip: _____

City, State, Zip: _____ Ins. Company Phone #: _____

Insurance ID#: _____ **Group ID#:** _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address of Policy Holder: _____ Address: _____

Address Line 2: _____ City, State, Zip: _____

City, State, Zip: _____ Ins. Company Phone #: _____

Insurance ID#: _____ **Group ID#:** _____

FORTUNE SMILES DENTAL

Dental Information

For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatments?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: ☐ Daily ☐ Weekly ☐ Sometimes			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam (mm/dd/yyyy):

What was done at that time?

Date of last dental x-rays (mm/dd/yyyy):

Anxiety seeing the dentist: ☐ None ☐ Mild ☐ Moderate ☐ Severe

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐
Physician Name: _____			
Phone: *include area code* (_____) _____			
Address/City/State/Zip: _____			
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
If yes, what condition was treated? _____			
Date of last physical exam: _____			
Do you wear contact lenses?	☐	☐	☐
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)?	☐	☐	☐
Are you taking or scheduled to begin taking either of the medications alendrontate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer?	☐	☐	☐
Date Treatment Began: _____			

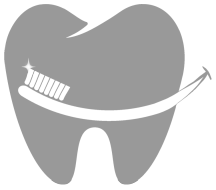
	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
If yes, what was the illness or problem? _____			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____			
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	
If so, how interested are you in stopping? Circle one: ☐ Very ☐ Somwhat ☐ Not Interested			
Do you drink alcoholic beverages?	☐	☐	
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormone replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? ☐ ☐

Date: _____ If yes, have you had any complications? ☐ ☐

Allergies - Are you allergic to, or have you had a reaction to: To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbituates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever / seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐



FORTUNE SMILES DENTAL

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

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

Have you ever had any serious illness not listed above? ☐ No ☐ Yes If yes, which? _____

Comments: _____

_____

_____

_____

_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?. . . . . .

Name of physician or dentist making recommendation:_____ Phone: (_____)_____

Do you have any disease, condition, or problem not listed above that you think I should know about?. . . . . .

Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevent patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will reyl on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FORTUNE SMILES DENTAL

Dental Treatment Consent

1. I authorize dental treatment including local anesthesia, examination, radiographs (x-rays) or diagnostic aids.
2. In general terms, dental treatment may include but is not limited to one or a number of the following:
• Administration of local anesthesia
• Cleaning of the teeth and application of topical fluoride
• Scaling and root planning with local anesthesia
• Application of sealants to the grooves of the teeth
• Treatment of disease or injured teeth with dental restorations. These restorations may either be amalgam (silver) or composite (white).
• Stainless steel crowns for children. These are necessary in cases where simple filling would not be the best long term restoration or in cases where there are large cavities.
• The replacement of missing teeth with a dental prosthesis (crown, partials, etc)
• Treatment disease or injured oral tissues (hard/or soft)
• Treatment of malposed (crooked) teeth and/or development abnormalities.
• Treatment of canal or pulp chamber that lies in the middle of the tooth and its root also known as "endodontic" therapy or (root canal treatment)

Risks of Dental Procedures in General
Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis (inflammation of the vein), reaction to injections, change in occlusion (biting), muscles cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of the teeth or restoration in the teeth, injury to other tissues, referred pain to the ear, neck, and head, nausea, allergic reactions, itching, bruising, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

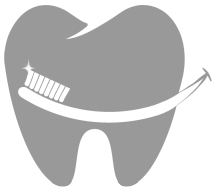
Changes in Treatment Plan
I understand that during treatment, it may be necessary to change and/or all procedures because of conditions found while working on the teeth that were not discovered during examination. Upon being informed, I will give my permission to the dentist to make any/all changes and addition as necessary.

Fillings
I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.

Crown (Caps) and Bridges
I understand that sometimes it is not possible to match the color of the 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 in place until the permanent crowns are delivered. I realize the final opportunity to make changes in any new crown or bridge (including shape, fit, size and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size, or color will incur an additional charge.

Alternative Treatment
I understand that I have the right to choose on the basis of adequate information, from alternate treatment plans that meet professional standards of care.
By signing below, I consent to the general dental treatments and/or proposed treatment.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____



Fortune Smiles Dental
1843 SW 8th Street
Miami, FL 33135
Tel: (786) 542-0977
Fax: (786) 275-4046

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Fortune Smiles Dental's Notice of Privacy Practices, which has an effective date of 09/23/2013, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____
Signature of Patient or Patient's Representative Date

_____
Print Name

_____
Relationship to Patient (If not signed by the Patient)

Fortune Smiles Dental
1843 SW 8th Street
Miami, FL 33135
Tel: (786) 542-0977
Fax: (786) 275-4046

NOTICE OF MATERIAL CHANGES TO OUR PRIVACY PRACTICES POLICY

EFFECTIVE: September 23rd. 2013

BACKGROUND

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) gives individuals the right to be informed of their healthcare providers' privacy practices and the right to understand and control how their health information is used. Healthcare providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices.
Our Practice has made material changes to our privacy practices, consistent with legal changes to HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). We will be providing all of our patients with our revised and updated Notice of Privacy Practices, and requesting a signed acknowledgment of receipt from each patient.

SUMMARY OF MATERIAL CHANGES TO OUR PRIVACY PRACTICES:

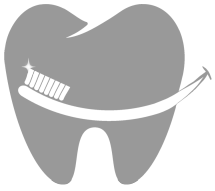
- We have added a statement to our Privacy Practices acknowledging that we may not use or disclose your protected health information for marketing purposes, including disclosures that constitute sales, without your authorization.
- We will be issuing new Patient Release of Records Authorization forms that allow patients to choose whether to allow or limit the Practice from disclosing their protected health information in certain ways, to include opting out of fundraising communications.
- If the Practice maintains a patient's psychotherapy notes, they will not be released unless you the patient signs an authorization or if otherwise required by law.
- Patients have the right to restrict the Practice from disclosing certain protected health information to health plan providers if the patient personally pays for their service in full.
- We have revised our internal privacy breach reporting practices to comply with 2013 changes in the HIPAA and HITECH privacy rules, and patients have a right to receive a notification of breaches of unsecured protected health information.
- Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose any genetic information to insurance providers or others for underwriting purposes.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Name: Tomas Acosta

Address: 1843 SW 8th Street Miami, FL 33135

Telephone: (786) 542-0977



FORTUNE SMILES DENTAL

Fortune Smiles Dental
1843 SW 8th Street
Miami, FL 33135
Tel: (786) 542-0977
Fax: (786) 275-4046

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are properly kept confidential. HIPAA gives you, the patient, significant rights to understand and control how your health information is used.

HIPAA provides penalties for covered entities, including our Practice, that misuse "protected health information" (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies takes effect on 09/23/2013, and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

You may request a copy of our current Notice of Privacy Practices at any time. For more information about our practices, or for additional copies, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your PHI 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, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office, or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends, and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your care. If you are present, prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death, or in emergency circumstances, if deemed appropriate based upon our professional judgment, we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. 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 obtain prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

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

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we may disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities. Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a sale of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI 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. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We will notify you of a breach of your unsecured PHI, as required by HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. 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 the additional requests. You have the right to request such an accounting in an electronic format.

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

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request, in writing, that we amend your PHI. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice of Privacy Practices on our website or by e-mail, you are entitled to receive a copy in written form.

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI. 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.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Name: Tomas Acosta

Address: 1843 SW 8th Street Miami, FL 33135

Telephone: (786) 542-0977