BRIDGELAND DENTISTRY

Patient Information:

Last Name:

First Name:

Middle Initial:

Preferred Name:

How did you hear about us? ◯ Insurance ◯ Online ◯ Flyer/Event
◯ Family/Friend:_____ ◯ Other:_____

Social Security Number:

Date of birth:

Marital Status:
◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Email Address:

Cell Phone:

Biological Sex:
◯ Male ◯ Female

Home Address:

City:

State:

Zip Code:

Address Line 2:

Home Phone:

Employer Information:

Employer:

Work Phone:

Work Address:

Work City:

Work State:

Work Zip Code::

Emergency Contact:

Emergency Contact:

Relation:

Phone:

Primary Dental Insurance Information:

Name of Insurance Company:

Phone Number:

Address:

City:

State:

Zip Code::

Policy Number:

Group Number:

If Patient is Not the Primary Insured:

First and Last Name of Primary Insured:

Relationship to Patient:

Address, if different from patient address above:

City:

State:

Zip Code:

Social Security Number of Primary Insured:

Email address of Primary Insured:

Phone Number of Primary Insured:

Employer of Primary Insured:

Work Phone:

Medical History

			For Staff Use Only
☐ Yes	☐ No	Are you under a physician's care? If yes:	Unless otherwise indicated below, add any "Yes" to the patient's "Problems" in Medical Window.
		Physicians Name: _____	
		Telephone: _____	
☐ Yes	☐ No	Are you currently taking any medications or substances? If yes, please list below. Examples: St. Johns Wart, Valarium, Ambien, etc.	Put all medications in Medications.
☐ Yes	☐ No	Are you allergic to any medications or substances, e.g. penicillin, amoxicillin?	Select in Allergies & type in Med Urgent
☐ Yes	☐ No	Are you sensitive or allergic to latex?	Also type in Med Urgent, **Blue Gloves**
☐ Yes	☐ No	Are you pregnant or suspect you might be?	
☐ Yes	☐ No	Do you use birth control medications?	
☐ Yes	☐ No	Do you have an artificial heart valve, prior history of infective endocarditis, congenital heart disease or heart transplant with complications?	Add to "Problems" and check box "Premedicate" in Medical Window
☐ Yes	☐ No	Do you have a pacemaker?	
☐ Yes	☐ No	Do you have high blood pressure?	
☐ Yes	☐ No	Have you every been diagnosed with Hepatitis?	
☐ Yes	☐ No	Have you ever had a major surgery or been hospitalized for any reason?	
☐ Yes	☐ No	Have you ever had radiation therapy in the head, neck and/or shoulders area?	Add to "Problems" and type "No Extractions" in Med Urgent
☐ Yes	☐ No	Do you have artificial joints or prosthesis? **If yes, please contact your doctor to discuss whether antibiotics are advised in connection with your dental visit today and, if so, to obtain those antibiotics.**	Add to "Problems" and check box "Premedicate" in Medical Window
☐ Yes	☐ No	Do you bleed excessively after being cut or injured?	
☐ Yes	☐ No	Are you diabetic?	
☐ Yes	☐ No	Do you smoke, chew or otherwise use any form of tobacco?	
☐ Yes	☐ No	Have you tested positive for HIV or been diagnosed with AIDS?	Add to "Problems" and type "No Benzo" in Med Urgent
☐ Yes	☐ No	Do you have acute narrow angle or untreated open angle glaucoma?	Add to "Problems" and type "No Benzo" in Med Urgent
		NOTE: Benzodiazepenes can cause complications when mixed with certain medicines routinely prescribed for the previous two conditions.	
☐ Yes	☐ No	Do you have any disease, condition, or problem not listed here? Please explain.	

I understand that (i) an accurate, complete medical history is necessary for my dentist and dental staff to be able to diagnose and perform dental services properly (including prescribing appropriate medications); (ii) serious consequences can arise if that information is not accurate and complete; and (iii) it is my responsibility to notify the office of any changes before further treatment. I certify that the information above and any updated information I provide is/will be accurate and complete when given. On behalf of myself, my heirs and/or assigns, I hereby release and hold Bridgeland Dentistry and its affiliates, and their owners, employees, agents, and contractors (including dentists), harmless from any and all claims, judgments, damages, liabilities, losses, costs and expenses, including attorneys' fees and costs, arising from or relating to any errors, omissions or misstatements (whether knowing or otherwise) in any medical information I provide.

Signature or Guardian's Signature:_____ Date:_____

Patient Printed Name:_____

Doctor Signature:_____ Date:_____

Bridgeland Dentistry
Patient X-Ray Policy

At Bridgeland Dentistry, your dental health is our number one priority. In order for us to best treat our patients and to comply with state law requirements, a full-mouth intraoral radiographic examination (FMX) is needed at your first appointment with Bridgeland Dentistry. If you have previously been a Bridgeland patient, but have not been seen in our office in the past three years, you are treated as a new patient.

Unfortunately, for a number of reasons, we are unable to transfer and/or use x-rays from other dental offices to meet this requirement. The taking of these x-rays may or may not be covered by your insurance plan, depending on your dental coverage and/or dental history. In particular, your insurance company may not cover these x-rays if you have had them taken too recently at a different office.

As a courtesy to our patients, we will file the claim for the x-rays with your insurance provider, if applicable. However, payment of unpaid claims is ultimately your responsibility, and any questions with regard to your benefits should be made by you directly to your insurance company. If your insurance company denies payment on the x-rays, you will be responsible to pay our cash-pay rate of $59 for the FMX, due upon receipt of invoice. This rate represents a discount from our usual and customary rate of $100 for the FMX.

I understand and agree to the above policy regarding Patient X-Rays at Bridgeland Dentistry.

_____ _____
Patient Name Patient's Date of Birth

_____ _____
Patient/Guardian Signature Date

Relationship, if not Patient:_____

REV.10.2022

Bridgeland Dentistry – BLD Office Policy

This Office Policy applies to any/all visits to Bridgeland Dentistry ("BLD"). Please read each item carefully. Please initial each item AND sign below to indicate your agreement.

Appointments

_____ Please notify our office in advance if you cannot keep your appointment. If you miss an appointment, or cancel an appointment later than noon on the business day prior to the appointment, we may charge a cancelation fee equal to $50 for each hour (or portion thereof) of the scheduled appointment time. We also reserve the right to ask you to seek care from another dentist if you miss three appointments without notification and/or cancel three appointments without notice before noon on the business day prior to the appointment.

- If you are more than 15 minutes late for your appointment, we will do the best we can to accommodate you without compromising your dental care. However, we reserve the right to treat this as a missed appointment and reschedule your appointment or to modify the procedures originally scheduled for that appointment.
- Our office may contact you with an appointment reminder as a courtesy to you. In order to facilitate this, please make sure that our office has your current contact information (phone, email, etc.) on file. However, you are expected to keep your scheduled appointment whether or not you receive a reminder notification.
- You hereby consent to receive reminders and other reasonable office notifications by text to any mobile phone number you provide to us. You may opt out of these notifications by providing written notice to our office prior to the notification being sent.

_____ We schedule appointments based on a treatment plan agreed to between you and the treating dentist. Occasionally, the dentist may need to make changes to the treatment plan during the course of treatment due to various factors, which may include, without limitation, changes in the condition of your mouth since the previous appointment (particularly if patient has delayed treatment), underlying condition(s) worse than initially indicated, difficulty with patient becoming or remaining numb, anatomical or other underlying conditions of the mouth that inhibit treatment, lack of patient cooperation during treatment, and patient non-compliance with treatment plan (such as failing to follow care instructions and/or to return for follow-up visits). In these cases, you understand that your appointment may need to be revised or rescheduled, or additional appointments scheduled, to reflect the updated treatment plan.

Photographs; Social Media

_____ Often, patients may desire to "check in" at BLD on social media and/or post or otherwise distribute images, updates or other information about their BLD visit. In these cases, we ask that you do not take or use pictures or video of dentists or BLD staff without their prior consent.

- Also, due to patient privacy laws, capturing images or any other information related to other patients of BLD without their consent is expressly prohibited. If you or anyone who accompanies you on a visit obtains and/or disseminates any images of our office or any protected patient information (whether knowing, intentional or otherwise), you hereby agree, on behalf of yourself, your representatives, heirs and assigns, to indemnify, release and hold Bridgeland Dentistry and its affiliates, and their owners, employees, agents, and contractors (including dentists), harmless from any and all claims, judgments, damages, liabilities, losses, costs and expenses, including attorneys' fees and costs, arising from or relating thereto.
- On occasion, we may ask patients to allow us to take images of them to post on social media or otherwise for our marketing. We will not do this unless we have obtained a written consent from you authorizing such use.

_____ In some cases, a treating dentist may need to take a photograph of your mouth or face during the course of treatment for clinical or cosmetic purposes. These images will be used only in connection with your treatment and for no other purpose. You hereby consent to our taking photographs for this limited purpose.

Miscellaneous

_____ We ask that you treat our dentists, staff and others with respect while in our office. We reserve the right to ask anyone to leave if they are verbally abusive or threatening in any way to dentists, staff, other patients, etc.

_____ Dentists who provide services for Bridgeland Dentistry may be independent contractors who may receive a portion of the fees we collect from you. You acknowledge and consent to this arrangement.

_____ We may update this BLD Office Policy and/or the BLD Financial Policy at any time by publishing the update to our website (www.bridgelanddentistry.com). Hard copies of current policies will be available at our front desk upon request.

Signature of Patient/Guardian:_____ Date:_____

Printed Name:_____ Date of Birth:_____

Bridgeland Dentistry – Financial Policy

This Financial Policy applies to any/all visits to Bridgeland Dentistry ("BLD"). Please read each item carefully. Please initial each item AND sign below to indicate your agreement.

Insurance

_____ Your insurance coverage, if any, is a contract between you and your insurance carrier. We are not a party to that agreement. Ultimately, YOU are responsible for knowing what your plan does and does not cover and any administrative rules that apply (e.g. in-network/out-of-network, copayments, waiting periods, deductibles, etc.).

- As a courtesy, we accept certain insurance plans. However, these plans change from time to time without notice to us, and it is your responsibility to confirm at each visit whether we still participate with your plan.
- It is your responsibility to provide us with your current insurance information at each visit. Failure to provide us with your current insurance information and/or to reply to requests for additional information from us or your insurance company may result in the entire bill being your responsibility.
- Each patient is encouraged to verify if, and to what extent, specific procedures are covered or not covered by their plan. We are no longer able to verify this for you, as insurance companies have not been providing us with reliable procedure fees before appointments are complete and insurance claims are filed.

_____ We diagnose and deliver treatment plans based on your health/dental needs, not based on your insurance coverage.

- Your treatment plan will reflect a maximum possible charge for your treatment. However, numerous factors determine final coverage, and we will not receive any final insurance coverage determination until your appointment is completed and a claim is filed and responded to by your carrier.
- The treatment plan will reflect an initial patient downpayment, which is due at the time services are rendered.

_____ Following your appointment, we will make reasonable efforts to file an initial claim with your insurance carrier with whom we have a contract agreement. Once your carrier has processed a claim, any balance determined by your carrier to be "patient's responsibility," "non-covered service," or similar designations will be your responsibility. All such amounts are due upon receipt of invoice.

- If your insurance company denies or downgrades a claim, or fails to respond within 90 days after the claim is filed, you are responsible for the balance on your account. We may, but are not obligated to, pursue such claims beyond the initial filing.
- If you disagree with the patient amounts due to our office as determined by your insurance company, you will need to handle your dispute directly with your insurance company.

_____ Occasionally, insurance companies may send payments in error and later issue corrections and/or requests for refunds.

- If your insurance company revises its determination of coverage and/or requests a refund of any amounts previously paid on a claim, at any time, you are responsible to pay any resulting balance on your account.
- If your insurance company overpays a claim, the overpayment will not be refunded to you or credited to your account, but will be held in escrow by us until returned to the insurance company. You agree that you have no claim to these funds.

_____ If you carry secondary insurance, we may file claims with your secondary insurance company as a courtesy, but we reserve the right to decline to file these claims or pursue appeals at any time.

General

_____ Balances are due at the time services are rendered, unless special arrangements have been made.

_____ We may refer you to independent specialists (e.g. oral surgeon, endodontist, periodontist, etc.) who will bill you for their services independently. All billing concerns with these offices should be addressed directly with them.

_____ Except as noted above, our office DOES NOT bill third parties (e.g. automobile insurance, workman's compensation). If you are eligible for third-party benefits outside of your primary dental insurance, you will be responsible to pay BLD for all amounts due, and a receipt will be given to you to file with the third party.

_____ We accept all major credit cards, checks, cash, and Care Credit. We also accept the SecureDent discount plan for cash-pay patients. For more information about the SecureDent plan and/or to sign up, please see the front desk.

_____ We reserve the right to charge a reasonable fee for transferring records to another dental office.

_____ There will be a $50 charge for all checks returned due to insufficient funds.

_____ If a refund is due to and payment is issued by check, you must pick up the check at our main office when available. We will send the check to you by mail, if you request. However, if that check is lost in the mail, and you request a second check to be issued, you will be responsible for a $50 stop payment charge to cancel the missing/lost check.

Signature of Patient/Guardian:_____ Date:_____

Printed Name:_____ Date of Birth:_____

Bridgeland Dentistry – Informed Consent

This Informed Consent applies to any/all visits to Bridgeland Dentistry ("BLD"). Please read each item carefully.

You have the right to accept or decline dental treatments recommended by your dentist. Before making these decisions, it is important to understand the benefits, common risks and potential complications of the recommended treatment, of alternative treatments and of declining treatment. Below are some general risks and considerations related to common procedures. At the time of any scheduled restorative treatment, you will be given more specific information regarding those procedures. Be certain your dentist has addressed all of your concerns to your satisfaction before commencing treatment.

Preventative Treatment (Hygiene)

_____ A routine dental prophylaxis (i.e. cleaning) involves the removal of light levels of plaque and calculus <u>above the gum line</u> and will not address periodontal disease. Following a routine cleaning, you may experience some symptoms such as tooth sensitivity or light bleeding.

- Occasionally during routine cleanings, existing fillings, crowns, orthodontic appliances, etc. may become dislodged. This typically does not occur unless there is an underlying condition present that requires attention. If this occurs, a dentist will provide you with a treatment plan to correct the condition and/or may refer you to the specialist who originally installed the appliance (e.g. your orthodontist).
- X-rays are necessary at least once per year to give you a complete examination, diagnosis and treatment plan.
- A periodic examination may be provided by a dentist at routine cleanings to evaluate your teeth for decay, gum disease, oral cancer and overall health. The dentist will read and diagnose any x-rays taken.

_____ If indicators of periodontal disease are discovered during a routine cleaning, you will be given information about this condition, as well as recommendations for dental treatment and home care, at that time. In these cases, it may be necessary to halt the routine cleaning and schedule other treatment and/or more in-depth cleaning, such as a gross debridement, two-part cleaning or scaling and root planing.

_____ You hereby consent to each routine dental prophylaxis, x-rays and examinations as and when scheduled by you.

Restorative Treatment

_____ In some cases, restorative procedures (e.g. fillings, crowns, etc.) may result in the need for more extensive restoration than originally diagnosed (e.g. root canal therapy or extraction) due to additional decay, unsupported tooth structure or other unforeseen factors that are found during preparation of the tooth. In these cases, the scope, timing and cost of treatment may need to be adjusted.

_____ Restorative dentistry involves placing prosthetics (e.g. crowns, bridges, implants, dentures, and fillings) in your mouth. <u>These prosthetics cannot and will not function or look exactly like your natural structures.</u>

_____ After restorative procedures, your bite may at times feel high, and you may need to return to have the bite adjusted.

General

_____ It is important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

_____ Though we strive for the best possible outcome for our patients, we cannot, by law, guarantee the success of any particular treatment. We do not offer warranties, as a variety of factors determine the outcome of any given treatment, including your unique physiology, health history and personal habits.

_____ Symptoms of popping, clicking, locking and pain may intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment when the mouth is held in the open position. However, symptoms of Temporomandibular Joint Dysfunction ("TMD") associated with dental treatment are usually temporary in nature and well tolerated by most patients. If the dentist determines you need treatment for TMD, you may be referred to a specialist, the cost of which is your responsibility.

_____ Failure to take medications prescribed to you as directed may offer risks of continued or aggravated infection, pain or a negative result on the outcome of your treatment. <u>Antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).</u>

Signature of Patient/Guardian:_____ Date:_____

Printed Name:_____ Date of Birth:_____

BRIDGELAND DENTISTRY

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgment *

Patient Name:_____ DOB:_____

I, the patient identified above, acknowledge that I have received a copy of this office's Notice of Privacy Practices.

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 the acknowledgment
▢ Other (Please Specify):

_____

_____

CHILDREN/DEPENDENTS

If applicable, I am signing the above Acknowledgement of Receipt of Privacy Practices, as well as the New Patient X-Ray Policy, BLD Financial Policy, BLD Office Policy and BLD Informed Consent on behalf of myself, as well as my children and/or other legal dependents who are patients of Bridgeland Dentistry, as listed below. (If you need more room, please add additional dependents below or on the back of this sheet.)

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES FOR THE OFFICES OF
Bridgeland Dentistry

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions about this notice, please contact

Bridgeland Dentistry
10615 Fry Rd., Suite B1-400, Cypress, Texas 77433
281-826-5900

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, contractors, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have aboutyour health, health status, and the health care and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

- ***For Treatment***

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care out- side this office and may require information about you that we have.

- ***For Payment***

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service.

- ***For Health Care Operations***

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

- ***Appointment Reminders***

We may contact you as a reminder that you have an appointment for treatment or medical care at the office. Please notify us if you do not wish to be contacted for appointment reminders.

- ***Health-Related Products and Services***

We may tell you about health-related products or services that may be of interest to you. Please notify us if you do not wish to receive communications about treatment alternatives or health-related products and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

- ***To Avert a Serious Threat to Health or Safety***

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- ***Required By Law***

We will disclose health information about you when required to do so by federal, state or local law.

- ***Organ and Tissue Donation***

If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

- ***Military, Veterans, National Security and Intelligence***

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

- ***Workers' Compensation***

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- ***Public Health Risks***

We may disclose health information about you for

public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

- ***Health Oversight Activities***

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- ***Lawsuits and Disputes***

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

- ***Law Enforcement***

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

- ***Coroners, Medical Examiners and Funeral Directors***

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

- ***Information Not Personally Identifiable***

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

- ***Family and Friends***

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse or friend when you bring your spouse or friend with you into the exam room during treatment or while treatment is discussed.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

- ***Right to Inspect and Copy***

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

- ***Right to Amend***

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

- ***Right to an Accounting of Disclosures***

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations.

It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- ***Right to Request Restrictions***

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

- ***We are Not Required to Agree to Your Request***

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit a Request For Restricting Uses and Disclosures and Confidential Communications.

- ***Right to Request Confidential Communications***

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For ex- ample, you can ask that we

only contact you at work or by mail.
To request confidential communications, you may complete and submit the Requests For Restricting Uses and Disclosures and Confidential Communications to:

Bridgeland Dentistry
10615 Fry Rd., Suite B1-400, Cypress, Texas 77433
281-826-5900

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- ***Right to a Paper Copy of This Notice***

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact

Bridgeland Dentistry
10615 Fry Rd., Suite B1-400, Cypress, Texas 77433
281-826-5900