PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

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

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

REFERRED BY

COMMANDING OFFICER #

Primary Insurance Information

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

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

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

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 9:59 AM | Norma Branson, DDS | Date 6/30/2021

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ 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, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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 Problems ◯ 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	Tonsilitis ◯ 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? ◯ Yes ◯ No If yes

Comments:

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. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

DENTAL SERVICES AGREEMENT

Dr. Norma Branson and the undersigned patient have agreed as follows:

ARTICLE 1. IT IS UNDERSTOOD THAT ANY DISPUTE AS TO DENTAL MALPRACTICE, THAT IS AS TO WHETHER ANY DENTAL SERVICES RENDERED UNDER THIS CONTRACT WERE UNNECESSARY OR UNAUTHORIZED OR IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED, WILL BE DETERMIND BY SUBMISSION TO ARBITRATION AS PROVIDED BY CALIFORNIA LAW, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. BOTH PARTIES TO THIS CONTRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE SUCH DISPUTE DECIDED IN COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF ARBITRATION.

ARTICLE 2. In the event of any claim, controversy or dispute the essential nature of which involve personal Injury. malpractice of any sort, by patient, dependents, whether or not minors, heirs at law or personal representatives against doctors or any doctor's officers, directors, shareholders, agents, employees, successors, in interest assigns or associated, agreeing in writing to bound by arbitration provisions of these (Affiliates"), THE SOLE METHOD POR RESOLVING SUCH DISPUTE SHALL BE BY BINDING ARBITRATION ADMINISTERED BY THE AMERICAN ARBITRATION ASSOCIATION accordance with the commercial arbitration rules of the American Arbitration Association. The parties hereby agree that they shall submit their controversy to an Arbitrator who ta a dentist licensed in the state of California. Such Arbitrator shall be acceptable to both parties. In the event that the parties. cannot agree upon a sole Arbitrator, each party shall pick an Association. Notwithstanding the foregoing, two additional Arbitrators who are dentist may be added by the parties by agreement in writing to create an arbitration panel of three. It is agreed that parties relevant to a full and complete settlement of any dispute subject to this agreement may be intervened or joined.

ARTICLE 3. The prevailing party in any arbitration pursuant to this agreement shall be awarded all cost, including reasonable attorney's fees, in prosecuting or defending the claim arbitration, but not to exceed $500.00 to amount Furthermore, If any action is undertaken to set aside or otherwise attack the binding arbitration award, the losing party In the court action shall hear all prevailing party costs, including reasonable attorney's fee and doctor's time value lost for the case.

ARTICLE 4. Any party Initiating Arbitration under this agreement shall file with his/her petition a bond or cash surely amount equal to Five Hundred Dollars ($500) that shall provide security for attorney's fees

ARTICLE 5. This Agreement shall govern all future services rendered to Patient by Doctor and Doctor's Affiliates and Associates; Execution of this agreement is a precondition to the furnishing of services by doctors but this agreement may be rescinded by written notice by either party within thirty days of signature. After those thirty days, this agreement may be charge or revoked only by written revocation signed by both parties.

ARTICLE 6 Doctor herby agrees to render dental care and service to patient. Patient agrees to pay Doctor promptly upon but at the rendering of a bill at the currently prevailing rates, or to cooperate with the doctor in obtaining payment from third party payers.

ARTICLE 7. Except for the indications made by the treating Doctor, professional services will not be rendered to patient unless this agreement to executed; the Doctor has made no other representation or statement, oral or written, to induce the patient into executing this agreement.

ARTICLE 8 in the event that any provisions of this agreement are void or unenforceable, then such provision shall be stricken and be of no force and effect. The remaining provision of this agreement, however, shall continue in full force and effect, and to the extent required shall be modified to preserve their validity. California Law shall govern this agreement.

THIS IS A BINDING LEGAL DOCUMENT, WHICH MAY HAVE AN IMPORTANT EFFECT ON YOUR LEGAL RIGHT. CONSULT YOUR ATTORNEY ON ANY QUESTIONS YOU MAY HAVE NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO HAVE A JURY OR COURT TRIAL SEE ARTICLE 1 OF THIS CONTRACT.

Patient or legal representative (print) _____ Relationship _____
Patient or Legal Representative Signature _____ Date _____
Dr. Signature _____ Date _____
Witness Signature _____ Date _____

Consent Form

EXAMINATION AND X-RAYS I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. Initial _____

DRUGS, MEDICATIONS AND SEDATION I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pein, itching, vomiting and/or anaphylactic shock (severe allergic reactions causing drowsiness and lack of awareness, bruising and swelling. In rare instances, partial or total lingering numbness may result. I understand that separation of the needle is also a rare occurrence. I understand the failure to take medications prescribed for me may offer risks of continued aggravated pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives. Initial

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 and crowns following routine restorative procedures. Initial _____

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD) I understand that symptoms of 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 will be tolerated by most patients, I understand that should the need of the treatment is my need for treatment arise, then responsibility. Initial _____

FILLINGS I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after affect of a newly placed filling. I understand that both composite and amalgam fillings are available. Initial _____

REMOVAL OF TEETH Alternative treatment for removal of teeth have been explained (root canal therapy, crowns periodontal surgery, etc.) and I authorize Dr. Branson to remove the following teeth, and any other for reasons stated above under changes in treatment. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, damage of adjacent teeth, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand 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. Initial _____

CROWNS, BRIDGES, CAPS, VENEERS AND BONDING I understand that sometimes it is not possible to match the color of my natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which come off easily, and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge or cap (including shape, fit, size and color) will be before cementation. I understand that in some cases teeth that have been treated with crowns, bridges, caps, veneers or bonding may require root canal treatment, the cost of which is my responsibility and which cannot always be predicted or anticipated and may require modification of daily cleaning procedures. Initial _____

DENTURES-COMPLETE OR PARTIAL I realize that full are partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new denture (including hape, fit, size, placement and color will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after the initial placement. The cost for this procedure is not included in the initial denture fee.
Initial _____

ENDODONTIC ROOT CANAL See separate informed consent form.

PERIODONTAL TREATMENT I understand that I have a serious chronic condition causing gum inflammation and/or bone loss and it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical treatment, gum surgery and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss dally, receive regular cleanings, a healthy diet, abstinence of tobacco products and following Dr. Branson's recommendations. Initial _____

I understand that dentistry is not an exact science and therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment which I have requested and authorized. I understand that Dr. Branson is responsible for the dental care rendered to me. I acknowledge the receipt of and understand post-operative Instructions and have been given an appointment date. I understand that for all treatment planned, I may choose to do nothing instead and understand the consequences of this choice.

Patient Signature _____ Date _____

SIGNATURE RELEASE STATEMENT

YOUR SIGNATURE IS NECESSARY FOR US TO:

1. **PROCESS ALL INSURANCE CLAIMS:**
2. **ENSURE PAYMENT FOR SERVICES PROVIDED**
3. **RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS**
4. **RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.**

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Norma Branson, DDS/Murphy Canyon Dental Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature _____

Patient Full Name (printed) _____

Parent Signature (if minor) _____

Witness _____

Date Signed _____

FINANCIAL INFORMATION

Responsible Party _____ Relationship _____ Daytime Phone _____

Address _____

Name of Primary
Insurance _____ ID# _____

Subscriber _____ Married Y or N Birthday _____ Relationship _____

Employer/Group
Name _____ Group# _____ SNN _____

FINANCIAL POLICY

As a condition for treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the cost incurred in their care. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid in full at the time the time services are performed. I understand that dental services provided are charged directly to me and that I am personally responsible for payment of all dental services. I understand that the fee estimate listed for this dental treatment can only be extended for a period of six months from the date of the patients examination.

I hereby authorize my insurance company to pay directly to Dr. Branson benefits accruing to me under my policy. **Assignment of Insurance** I understand that this office will help prepare my insurance forms to assist making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. I understand that it is my responsibility to take care of applicable deductibles, co-payments co-insurance and outstanding balances at the time services are rendered. If for any reason my dental insurance plan does not pay for the services rendered, I acknowledge responsibility for all charges and I agree to pay upon receipt of statement.

In consideration for the professional services rendered to me, or at the request of Dr. Branson or her staff, I agree to pay the reasonable value of said services to Dr. Norma Branson at the time services are rendered. I further agree that the reasonable value of said services shall be billed unless objected by me, in writing within the time of payment. A reasonable interest rate will be charged on the unpaid principal balance of all accounts not paid within 60days of the treatment date. Additionally, I agree that a waiver for any breach of any term or condition to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney and collection fees. I grant my permission to Dr. Norma Branson or her staff to telephone me at home or my work to discuss matters related to this form. I have read the above condition of treatment and agree to the content.

Signature of Responsible Party _____ **Date** _____

Broken Appointment Policy

Our office has a very strict broken appointment policy:

We require a 48 hour notice to change or cancel an appointment to avoid a $50.00 broken appointment fee.

We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us a 48 hours' notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Policy and Fees:

Cancellation or rescheduling of an appointment with 48 hours or more notification - no charge

Cancellation or rescheduling of an appointment less than 48 hours - $50.00 fee

Definition of "Broken Appointment":

Cancel or reschedule an appointment with less than a 48 hour notice

Do not show up for the scheduled appointment

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized. We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, please do not hesitate to ask.

I have read and understand the above mentioned policy.

Patient Signature _____

Date _____

HIPPA NOTICE OF PRIVACY PRACTICES
FOR THE OFFICE OF
Norma Branson DDS 5250
5250 Murphy Canyon Road
Suite #122
San Diego, CA 92123
(858)268-8112

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations Examples of how we use or disclose information for treatment purposes are setting an appointment examining your teeth prescribing medications and faxing them to be filled referring you to another doctor or getting copies from another professional that you may have seen before us Examples of how we use or disclose your health information for payment purposes are asking you about your health or dental care plans, or other sources of payment preparing and sending bills or claims and collecting unpaid amounts (wither ourselves or through a collection agency or attomey) Health care operations" mean those administrative and manageable functions that we have to do in order to run our office Examples of how we use or disclose your health information for health care operations are financial or billing audits personnel decisions defense of legal matters business planning and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

We will ask for special written permission in the following situation

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us: some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose for public heath purposes, such as contagious disease reporting, investigation or surveillance and notices to and from the federal Food and Drug Administration regarding drugs or medical devices.
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence
- uses and disclosures for health oversight activities such as for the licensing of doctors for audits by Medicare or Medicaid, or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas.
- disclosures for law enforcement purposes such as to provide information about someone who is or is suspected to be a victim of a crime in our office or somewhere else
- disclosure to a medical examiner or funeral director to identify a person or to determine the cause of death or to organizations that handle organ or tissue donations
- uses or disclosures for health-related research
- uses and disclosures to prevent a serious threat to health or safety
- uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials
- disclosures of de-identified information
- disclosures relating to worker's compensation programs
- disclosures of a "limited data set" for research, public health, or health care operations,
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures your health information
  sociates who perform health care operations for us and who commit to respect the privacy of Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care We may call or write to remind you of scheduled or routine appointments We may also call or write to notify you of other

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled or routine appointments. We may also call or write to notify you of other treatments or services available for you. Unless you tell us otherwise, we may mal reminders on a post card, and/or leave a message on your home answering machine or someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form. The content of an "authorization form" is determined by federal law.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice. Additional fees may apply.
- ask to see or to get photocopies of your health information. By law, there are a few situations in which we can refuse to permit access of copying, however, you will be able to review or have a copy of your health information within 30 days. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or Email shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or Email shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want) By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization, incidental disclosures; disclosures required by law, and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request it does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, we will post the new notice in our office, have copies available in our office, and post it on our Web site and in your health history information.

COMPLAINTS

If you think that we have not property respected the privacy of your health information, you are free to complain to us or the US Department of Health and Human Services Office for Civil Rights. We will not retaliate against you if you make a complaint to complain to us, send a written complaint to the office contact person at the address. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

I authorized Dr. Branson´s Office to communicate thru TEXT AND E-MAILS.

_____

SIGNATURE

tear here

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Norma Branson DOS Notice of Privacy Practices

Patient name _____

Signature _____ Date _____

Murphy Canyon Dental Group

Dr. Norma Branson, DDS

ACKNOWLEDGEMENT OF RECEIPT

I _____ have received or have been offered a copy of Murphy Canyon Group Notice of Privacy Practices.

Patient Name (please print)

_____

Signature or Guardian:

_____

_____

FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgment of receipt of our *Notice of Primary Practices,* but acknowledgement could be obtained because:

_____ Individual refused de sign
_____ Communication barriers prohibited obtaining the acknowledgment
_____ An emergency situation prevented us from obtaining acknowledgment
_____ Other (Please Specify)

PLEASE LIST ANYONE WITH WHOM WE MAY DISCUSS YOUR TREATMENT