

HEAD, NECK AND FACIAL PAIN QUESTIONNAIRE

Form 401A

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

PATIENT INFORMATION

TODAY'S DATE _____

MR. MS. MISS MRS. DR. NAME: _____
First Middle Initial Last

AGE: _____ BIRTH DATE: _____ MALE FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

MARITAL STATUS: Single Married Widowed Divorced Other

RESPONSIBLE PARTY: _____

FAMILY DENTIST: _____

ADDRESS: _____

FAMILY PHYSICIAN: _____

ADDRESS: _____

REFERRED BY: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please **number** your complaints with #1 being the most severe symptom, #2 the next, etc.

2. Then rate your complaints for frequency and intensity:

Frequency:

(1- SELDOM, 2-OCCASIONAL, 3- FREQUENT, 4- EVERY DAY)

Intensity:

(0 is NO PAIN and 10 is MOST SEVERE PAIN)

Number	Frequency	Intensity
#1 = the most severe symptom	1-4	0-10
_____ Back Pain	_____	_____
_____ Dizziness	_____	_____
_____ Ear Congestion	_____	_____
_____ Ear Pain	_____	_____
_____ Eye Pain	_____	_____
_____ Facial Pain	_____	_____
_____ Fatigue	_____	_____
_____ Headaches	_____	_____
_____ Inability to open mouth	_____	_____
_____ Jaw Clicking	_____	_____
_____ Jaw Joint Noises	_____	_____
_____ Jaw Locking	_____	_____
_____ Jaw Pain	_____	_____
_____ Limited Mouth Opening	_____	_____
_____ Migraine Headaches	_____	_____
_____ Muscle Twitching	_____	_____
_____ Neck Pain	_____	_____
_____ Pain when Chewing	_____	_____
_____ Ringing in the Ears	_____	_____
_____ Shoulder Pain	_____	_____
_____ Sinus Congestion	_____	_____
_____ Throat Pain	_____	_____
_____ Visual Disturbances	_____	_____
_____ Other - write in:	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature

Date

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

- | | | |
|--|---|--|
| Y <input type="checkbox"/> N <input type="checkbox"/> Antibiotics | Y <input type="checkbox"/> N <input type="checkbox"/> Latex | Y <input type="checkbox"/> N <input type="checkbox"/> Sedatives |
| Y <input type="checkbox"/> N <input type="checkbox"/> Aspirin | Y <input type="checkbox"/> N <input type="checkbox"/> Local anesthetics | Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pills |
| Y <input type="checkbox"/> N <input type="checkbox"/> Barbiturates | Y <input type="checkbox"/> N <input type="checkbox"/> Metals | Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa drugs |
| Y <input type="checkbox"/> N <input type="checkbox"/> Codeine | Y <input type="checkbox"/> N <input type="checkbox"/> Penicillin | Y <input type="checkbox"/> N <input type="checkbox"/> Other _____ |
| Y <input type="checkbox"/> N <input type="checkbox"/> Iodine | Y <input type="checkbox"/> N <input type="checkbox"/> Plastic | _____ |

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

- | | | |
|--|--|---|
| Y <input type="checkbox"/> N <input type="checkbox"/> Antibiotics | Y <input type="checkbox"/> N <input type="checkbox"/> Cortisone | Y <input type="checkbox"/> N <input type="checkbox"/> Nerve pills |
| Y <input type="checkbox"/> N <input type="checkbox"/> Anticoagulants | Y <input type="checkbox"/> N <input type="checkbox"/> Diet pills | Y <input type="checkbox"/> N <input type="checkbox"/> Pain medication |
| Y <input type="checkbox"/> N <input type="checkbox"/> Barbiturates | Y <input type="checkbox"/> N <input type="checkbox"/> Heart medication | Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pills |
| Y <input type="checkbox"/> N <input type="checkbox"/> Blood thinners | Y <input type="checkbox"/> N <input type="checkbox"/> Insulin | Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa drugs |
| Y <input type="checkbox"/> N <input type="checkbox"/> Codeine | Y <input type="checkbox"/> N <input type="checkbox"/> Muscle relaxants | Y <input type="checkbox"/> N <input type="checkbox"/> Tranquilizers |

Other _____

PLEASE LIST ANY TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING:

Practitioner	Specialty	Treatment & approximate date
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____

MEDICAL HISTORY (Please indicate dates on questions checked YES)

- | | | |
|---|---|---|
| Y <input type="checkbox"/> N <input type="checkbox"/> Adenoids Removed | Y <input type="checkbox"/> N <input type="checkbox"/> Current pregnancy | Y <input type="checkbox"/> N <input type="checkbox"/> General anesthesia |
| Y <input type="checkbox"/> N <input type="checkbox"/> Tonsils Removed | Y <input type="checkbox"/> N <input type="checkbox"/> Depression | Y <input type="checkbox"/> N <input type="checkbox"/> Glaucoma |
| Y <input type="checkbox"/> N <input type="checkbox"/> Anemia | Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes | Y <input type="checkbox"/> N <input type="checkbox"/> Gout |
| Y <input type="checkbox"/> N <input type="checkbox"/> Arteriosclerosis | Y <input type="checkbox"/> N <input type="checkbox"/> Difficulty concentrating | Y <input type="checkbox"/> N <input type="checkbox"/> Hay fever |
| Y <input type="checkbox"/> N <input type="checkbox"/> Asthma | Y <input type="checkbox"/> N <input type="checkbox"/> Dizziness | Y <input type="checkbox"/> N <input type="checkbox"/> Hearing impairment |
| Y <input type="checkbox"/> N <input type="checkbox"/> Autoimmune disorders | Y <input type="checkbox"/> N <input type="checkbox"/> Emphysema | Y <input type="checkbox"/> N <input type="checkbox"/> Heart murmur |
| Y <input type="checkbox"/> N <input type="checkbox"/> Bleeding easily | Y <input type="checkbox"/> N <input type="checkbox"/> Epilepsy | Y <input type="checkbox"/> N <input type="checkbox"/> Heart disorder |
| Y <input type="checkbox"/> N <input type="checkbox"/> Blood pressure <input type="checkbox"/> High <input type="checkbox"/> Low | Y <input type="checkbox"/> N <input type="checkbox"/> Excessive thirst | Y <input type="checkbox"/> N <input type="checkbox"/> Heart pacemaker |
| Y <input type="checkbox"/> N <input type="checkbox"/> Bruising easily | Y <input type="checkbox"/> N <input type="checkbox"/> Fluid retention | Y <input type="checkbox"/> N <input type="checkbox"/> Heart palpitations |
| Y <input type="checkbox"/> N <input type="checkbox"/> Cancer | Y <input type="checkbox"/> N <input type="checkbox"/> Frequent cough | Y <input type="checkbox"/> N <input type="checkbox"/> Heart valve replacement |
| Y <input type="checkbox"/> N <input type="checkbox"/> Chemotherapy | Y <input type="checkbox"/> N <input type="checkbox"/> Frequent illnesses | Y <input type="checkbox"/> N <input type="checkbox"/> Hemophilia |
| Y <input type="checkbox"/> N <input type="checkbox"/> Chronic fatigue | Y <input type="checkbox"/> N <input type="checkbox"/> Frequent stressful situations | Y <input type="checkbox"/> N <input type="checkbox"/> Hepatitis |
| Y <input type="checkbox"/> N <input type="checkbox"/> Cold hands & feet | Y <input type="checkbox"/> N <input type="checkbox"/> Fibromyalgia | Y <input type="checkbox"/> N <input type="checkbox"/> Hypoglycemia |

Patient Signature _____ Date _____

MEDICAL HISTORY CONTINUED

- Y N Immune system disorder
- Y N Injury to
 - Face Mouth
 - Neck Teeth
- Y N Insomnia
- Y N Intestinal disorders
- Y N Jaw joint surgery
- Y N Kidney problems
- Y N Liver disease
- Y N Meniere's disease
- Y N Menstrual cramps
- Y N Multiple sclerosis
- Y N Muscle aches
- Y N Muscle shaking (tremors)
- Y N Muscle spasms or cramps

- Y N Muscular dystrophy
- Y N Needing extra pillows to help breathing at night
- Y N Nervous system irritability
- Y N Nervousness
- Y N Neuralgia
- Y N Osteoarthritis
- Y N Osteoporosis
- Y N Ovarian cysts
- Y N Parkinson's disease
- Y N Poor circulation
- Y N Prior orthodontic treatment
- Y N Psychiatric care
- Y N Radiation treatment
- Y N Rheumatic fever
- Y N Rheumatoid arthritis
- Y N Scarlet fever

- Y N Shortness of breath
- Y N Sinus problems
- Y N Skin disorder
- Y N Slow healing sores
- Y N Speech difficulties
- Y N Stroke
- Y N Swollen, stiff or painful joints
- Y N Tendency for:
 - Frequent Colds
 - Ear Infections
 - Sore Throats
- Y N Tired muscles
- Y N Tuberculosis
- Y N Tumors
- Y N Urinary disorders
- Y N Wisdom teeth (Third Molar) extraction

Other _____

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

L= Left R=Right B=Both sides

HEAD PAIN	LOCATION	SEVERITY			FREQUENCY			DURATION					
		MILD	MODERATE		OCCASIONAL (MONTHLY OR LESS)	FREQUENT (WEEKLY)	CONSTANT (EVERY DAY)	SECONDS	MINUTES	HOURS	DAYS	WEEKS	
				SEVERE									
L R B	Front of your head (Frontal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Entire head (Generalized)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Top of your head (Parietal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Back of your head (Occipital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	In your temples (Temporal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

JAW PAIN

- L R B Jaw pain - on opening
- L R B Jaw pain - while chewing
- L R B Jaw pain - at rest

JAW SYMPTOMS

- Y N Jaw clicks
- Y N Jaw locks closed
- Y N Jaw locks open
- Y N Jaw popping
- Y N Teeth clenching
- Y N Teeth grinding

EYE RELATED CONDITIONS

- Y N Blurred vision
- Y N Double vision
- Y N Eye pain
- Y N Pain or pressure behind the eyes
- Y N Photophobia (extreme sensitivity to light)

EAR RELATED CONDITIONS

- Y N Buzzing in the ears
- Y N Ear congestion
- Y N Ear pain
- Y N Hearing loss
- Y N Pain behind the ear
- Y N Pain in front of the ear
- Y N Recurrent ear infections
- Y N Tinnitus (ringing in the ear)

THROAT NECK & BACK RELATED CONDITIONS

- Y N Back pain - lower
- Y N Back pain - middle
- Y N Back pain - upper
- Y N Chronic sore throat
- Y N Constant feeling of a foreign object in throat
- Y N Difficulty in swallowing
- Y N Limited movement of neck
- Y N Neck pain
- Y N Numbness in the hands or fingers

Patient Signature _____

Date _____

THROAT NECK & BACK RELATED CONDITIONS (Continued)

- Y N Sciatica
- Y N Scoliosis
- Y N Shoulder pain
- Y N Shoulder stiffness
- Y N Swelling in the neck
- Y N Swollen glands
- Y N Thyroid enlargement
- Y N Tightness in throat
- Y N Tingling in the hands or fingers
- Y N Wryneck

MOUTH & NOSE RELATED CONDITIONS

- Y N Broken teeth
- Y N Burning tongue
- Y N Chronic sinusitis
- Y N Dry mouth
- Y N Frequent biting of cheek
- Y N Frequent snoring

Other _____

HISTORY OF SYMPTOMS

When did your condition first occur? _____

What do you believe is the cause of your pain or condition?

Pick one:

- Motor vehicle accident
- Motorcycle accident
- Work related incident
- Playground incident
- Athletic endeavor
- Fight
- Fall
- Accident
- Illness
- Injury
- Unknown
- Other _____

If accident, date _____

Is there anything that makes your pain or discomfort worse? _____

Is there anything that makes your pain or discomfort better? _____

What other information is important to your pain or condition? _____

FAMILY HISTORY

- Have any members of your family (blood kin) had:
- Y N Headaches
 - Y N High blood pressure
 - Y N Heart disease
 - Y N Diabetes

SOCIAL HISTORY

Occupation _____

Do you have children? Y N If yes, how many children? _____ What are their ages? _____

Y N Are you currently under unusual stress?

Y N Do you chew tobacco?

Y N Recent change in lifestyle?

Number of caffeine drinks per day _____

Y N Do you exercise regularly?

Y N Do you smoke?

_____ Number of Packs Day
 Cigarettes per Week




Alcohol consumption

None Social Drinker
 Occasional Daily

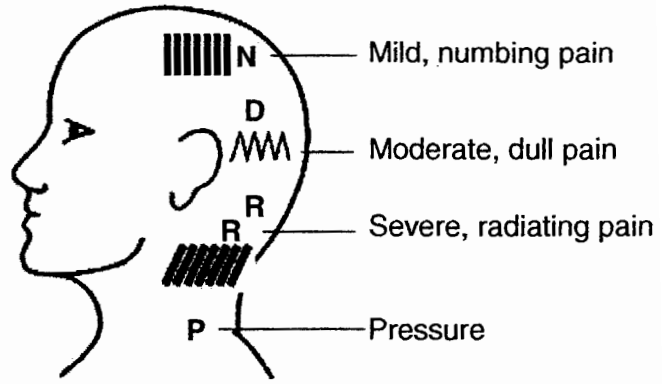
Patient Signature _____

Date _____

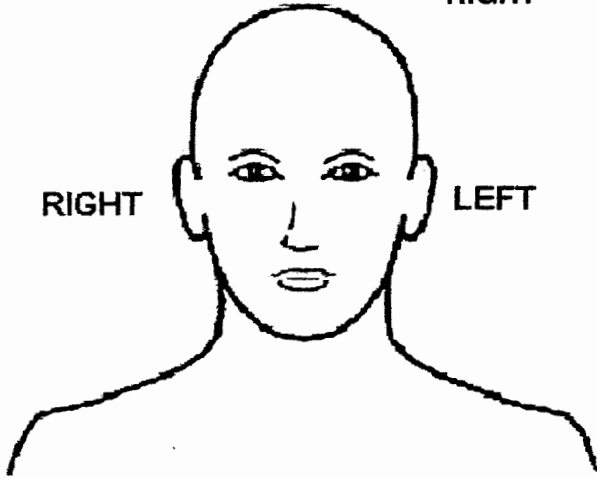
**DRAW YOUR PAIN PATTERNS
FOLLOWING THIS KEY:**

MILD PAIN		B Burning
		D Dull
		N Numbing
MODERATE PAIN		P Pressure
		S Sharp
		T Tingling
SEVERE PAIN		R Radiating

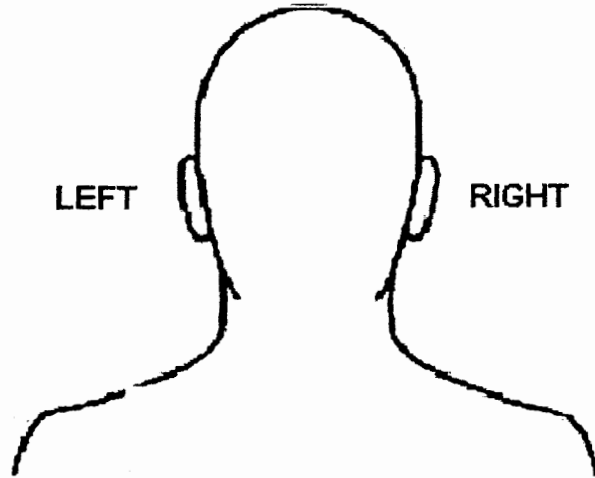
EXAMPLE



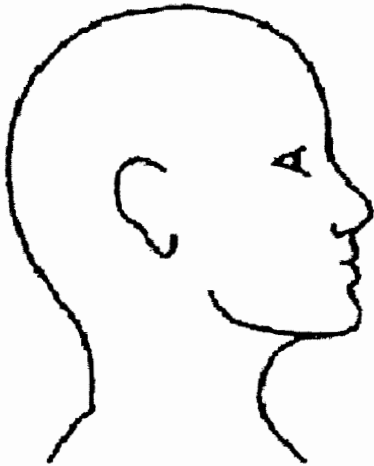
RIGHT



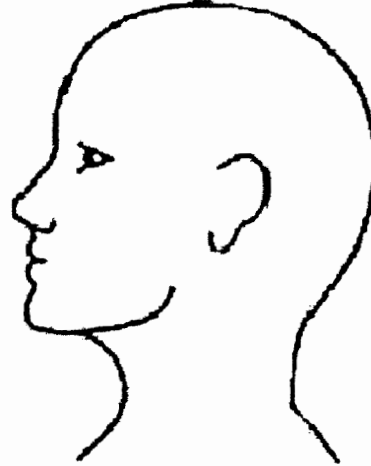
LEFT



RIGHT



LEFT



Patient Signature _____

DENTAL CENTER OF NAPERVILLE
Dr. Hitesh K. Patel DDS

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is a set of questions that have been used to evaluate the restfulness of a patient. Though it is not a true test that can prove you have sleep apnea, it certainly can suggest that you are more prone to fall asleep than others and should be evaluated by a physician. The questions are useful assuming that you are sleeping regularly and are in your usual state of health.

For the following situations, answer with one of the following numbers:

- 0- Would never doze**
- 1- Slight chance of dozing**
- 2- Moderate chance of dozing**
- 3- High chance of dozing**

Situation	Score
Sitting and reading	_____
Watching Television	_____
Sitting, inactive in a public place	_____
As a passenger in a car for an hour Without a break	_____
Lying down to rest in the afternoon When circumstances permit	_____
Sitting and talking to someone	_____
In a car, while stopped for a few Minutes in traffic	_____
Total Score	_____

DENTAL CENTER OF NAPERVILLE

Throat, Mouth and Jaw
Posture and Muscle Function Disorders

Hitesh K. Patel, D.D.S., F.I.C.C.M.O
1060 E. Ogden Ave
Naperville, IL 60563

FREQUENT TMJ SYMPTOMS

Many symptoms may be associated with jaw problems. Body systems are inter related and cannot be separated. The following is a list of symptoms that are frequently managed with the services provided by TMJ Associates. Please indicate which of these are of concern to you, without regard to their possible origin. You may also add any other symptoms. Thank you.

Pain Problems

1. Head Pain
2. Neck Pain
3. Facial Pain
4. Ear (dizziness, stuffiness, etc.)
5. Other

Problems with Jaw Use

1. Difficulty Eating
2. Difficulty Speaking
3. Limited opening, Locking
4. Other

Appearance

1. Poor Posture
2. Dark Circles Under Eyes
3. Tired Appearance
4. Weight Concerns

Stress Feelings

1. Fight or Flight feeling (Panic attacks)
2. Feeling "Driven", Always Thinking
3. Feeling restless when laying down
4. Other

Snoring

1. Loud
2. Concern to Others
3. Awaken yourself, snorts, gasps
4. Startled Awakening, Rapid heart rate

Poor Sleep

1. Tired in the day, low energy level
2. Restless sleep
3. Nighttime or Morning Pain

Other

Signed _____ Date _____

Diplomat of American Academy of Pain Management, Fellow of International College of Cranio-Mandibular Orthopedics
Fellow Academy of Dentistry International, Fellow American College of Forensic Examiners, American Academy of
Craniofacial Pain, American Academy of Dental Sleep Medicine, American Dental Association, Chicago Dental Society,
Illinois State Dental Society, Academy of General Dentistry, Associate Member of the Cranial Academy

FINANCIAL POLICY
ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental or medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services and/or co-payments is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. Co-payments are the percentage that the insurance company won't pay, generally between 30-50% and it will be collected at the time services are rendered. We accept cash, checks, MasterCard, Visa and Discover. We will be happy to help process your insurance claim-form.

Returned checks and balances older than 30 days may be subject to additional collection fees. Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a part of that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary, and reasonable.

This statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, or allowances, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that, as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you do have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

PATIENT SIGNATURE

Date

Dental Center of Naperville

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____ E-mail: _____
Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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

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

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

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

Contact Person: Dental Center of Naperville
Telephone: Hitesh K. Patel, D.D.S.
E-mail: 1060 E. Ogden Ave.
Address: Naperville, IL 60563

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

SIGNATURE

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

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

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

Hitesh K. Patel

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

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

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

REVOCAION OF CONSENT

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

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

Signature: _____ Date: _____

Hitesh K. Patel D.D.S.

NOTICE OF PRIVACY PRACTICES

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

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

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make

reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

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

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.____ for each page, \$____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

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

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.