GROVE PARK
DENTAL GROUP

PATIENT LAST NAME: _____ **FIRST:** _____ **MIDDLE:** _____

How do you wish to be addressed? _____ SSN: _____ Date of Birth _____

Address _____ City _____ State: _____ Zip _____

Telephone (Mobile) _____ (Work) _____ (Home) _____

Email _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name _____	Subscriber Name _____
Subscriber ID _____	Subscriber ID _____
Subscriber ID _____	Subscriber ID _____
Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____
Insurance Company _____	Insurance Company _____
Insurance Group _____	Insurance Group _____
Insurance Phone _____	Insurance Phone _____

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY (If other than Patient)

Last Name: _____ First: _____ Middle: _____

Address *(If different)* _____ Date of Birth _____

City _____ State: _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Relationship to Patient _____

Email _____SSN_____

EMERGENCY CONTACT

Last Name: _____ First: _____ Middle: _____

Telephone (☐ Mobile ☐ Work ☐ Home) _____

Relationship to Patient _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS. I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time by contacting the office at (901) 683-9800.

I attest to the accuracy of the information on this page.

Signature _____ Date _____

(Responsible Party or Parent if under 18)

PATIENT REGISTRATION

MEDICAL HISTORY

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, vitamins, or herbal supplements?	☐ 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		

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 use controlled substances? ☐ Yes ☐ No If yes

MEDICAL HISTORY

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

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

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

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 my 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: _____

MEDICAL HISTORY

DENTAL HISTORY

Reasons for today's visit: _____ Date of last dental visit: _____

Former Dentist: _____ Date of last dental x-rays _____

Please check if you have/had:

Bad breath	☐ Yes	☐ No	Head, neck, jaw pain, or aches	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Smokeless tobacco	☐ Yes	☐ No	Nitrous Oxide	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No	Sensitivity to pressure or irritants	☐ Yes	☐ No
Clench or grind teeth	☐ Yes	☐ No	(cold, heat, sweets)		
Growths or sore spots in your mouth	☐ Yes	☐ No	How often do you floss? _____		
Gums swollen, tender or bleeding	☐ Yes	☐ No	How often do you brush? _____		

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? ☐ Yes ☐ No

If Yes, please explain _____

_____

Have you ever had trouble from previous dental care? ☐ Yes ☐ No

If Yes, please explain _____

_____

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 my 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 HISTORY

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Telephone: _____ E-Mail: _____

Patient Number: _____ Social Security Number: _____

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 the 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:

Privacy Officer: KaShaundra Atkinson

Telephone: (901) 683-2800

Address: 4515 Poplar Avenue, Suite 406, Memphis, TN 38117

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.

SECTION C: SIGNATURE

I, _____have had full opportunity to read and consider the contents of this Consent form and the 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 heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION D: 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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____

Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it.

PRIVACY PRACTICES RECEIPT / CONSENT FORM

SECTION E: REVOCATION 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: _____ Date: _____

If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION F: PATIENT/RELATIVE HIPAA CONSENT

I, _____ , understand that by signing this Consent form, I am giving my consent to Grove Park Dental Group to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Name: _____

Relationship: _____

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 Compliance Officer listed on Section B.

_____ _____

Patient's Signature (Legal Guardian, if Patient is a minor) Date

SECTION G: RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

I request Grove Park Dental Group restrict the disclosure of my PHI to those specified below:

Name: _____

Name: _____

Signature: _____ Date: _____

If this Restriction of PHI is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

PRIVACY PRACTICES RECEIPT / CONSENT FORM

Grove Park Dental Group, PLLC
Financial Policy

PATIENT NAME: _____ **DATE:** _____

Grove Park Dental Group, "GPDG", is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.**
- **GPDG PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card, Discover or American Express.

INSURANCE

GPDG provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by GPDG staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to GPDG. However, if you are paid by the insurance company instead of GPDG, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. You as a patient are always responsible for any charges that are not covered by your insurance.

DELINQUENT PAYMENTS

It is our policy to charge finance fees at 1.5% monthly for outstanding patient balances after the balance has been outstanding 30 days. If the account is referred to any agency or attorney for collections purposes, the responsible party agrees to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

MISSED APPOINTMENTS

Our goal is to provide treatment in a timely manner. In order to provide the best service to our patients, we require at least a 24 hour notice for cancellations or re-scheduling your appointments. Unless cancelled at least 24 hours in advance, a $50.00 charge may be assessed for missed appointments or last minute cancellations. Please help us service you better by keeping scheduled appointments.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature _____ **Date** _____

GPDG FINANCIAL POLICY

Grove Park Dental Group, PLLC
Notice of Privacy Practices

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.

PURPOSE: Grove Park Dental Group, PLLC, hereafter referred to as "Practice," follow the privacy practices described in this Notice. The Practice is required by law to maintain the privacy of your health information and to protect the integrity, confidentiality, and availability of your health information when it is collected, maintained, and transmitted. You may access or obtain a copy according to the following options: 1) contact the office and request a copy to be sent to you by mail or email, 2) request a copy at the time of your next appointment. This notice takes effect 09/23/2015 and remains in effect until we replace it.

1. USES & DISCLOSURES OF PROTECTED HEALTH INFORMATION ("PHI"): Your PHI may be used and disclosed by our Practice's dentist, administrative and or clinical staff and others outside of our Practice who are involved in your care and treatment for the purpose of providing healthcare services to you. This includes dental records, dental x-rays and payment information. This also includes information such as sensitive information including your social security number, credit card number, and other identifiable information in addition to sensitive medical information such as HIV status.
A) Treatment: We will use and disclose your PHI to provide, coordinate or manage your dental care and any related services. We may disclose PHI to other providers who may be treating you such as a specialist.
B) Payment: We will use your PHI to obtain payment for the dental care services provided by this Practice. For example, if we are working with your insurance plan, we may verify eligibility or coverage for benefit determination. We may use or disclose your information so that a bill may be sent to you that may include services provided.
C) Healthcare Operations: The Practice may use or disclose, as needed, your PHI in order to support its business activities such as quality performance reviews regarding our services or the performance of our staff. i) Business Associates: We may share your PHI with third party business associates such as answering services, transcriptionists, billing services, consultants, trainers and legal counsel. We obtain a written agreement between our Practice and the business associate to assure the protection and privacy of your PHI. Business Associates are asked to disclose if they are working with subcontractors.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object: We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object as follows:

D) Required or Permitted by Law: We may use or disclose your PHI as required by law. This may include public health activities such as controlling a communicable disease or compliance with health oversight agencies authorized by law. We may disclose PHI to a public health authority authorized to receive reports of child abuse or neglect. We may disclose your PHI if we believe you have been a victim of abuse, neglect or domestic violence to a governmental agency authorized to receive such information in compliance with state and federal law. We may disclose your PHI to the Food and Drug Administration for the quality, safety, or effectiveness of FDA-regulated products or activities. We may disclose your PHI in the course of a legal proceeding in response to a subpoena, discovery request or other lawful process. We may also disclose PHI to law enforcement providing applicable legal requirements are satisfied. We may disclose PHI to a coroner or medical examiner for identification purposes. We may disclose PHI to researchers when the information does not directly identify you as the source of the information and such research has been approved by an institutional review board to ensure the privacy of the PHI. We may disclose PHI as authorized to comply with workers' compensation laws. We may use and disclose your PHI if you are an inmate of a correctional facility and this information is necessary for your care.

Authorization for Other Uses and Disclosures of PHI: Use and disclosure of your PHI not addressed in this Notice of Privacy Practices will be made only with your written authorization. You may revoke this authorization in writing at any time. If you revoke this authorization, we will no longer use or disclose your PHI; however, we are unable to retrieve previous disclosures made with your prior authorization.

Other Permitted and Required Uses and Disclosures that Require Your Permission or Objection:

i) Students: We may share PHI with students working in our Practice to fulfill their educational requirements. If you do not wish a student to observe or participate in your care, please notify your provider.

ii) Appointment Reminders: We may contact you as a reminder of your appointment. Only limited information is provided on an answering machine or an individual other than you answering the call. We may issue a post card or letter notifying you that it is time to make an appointment. You may provide a preferred means of contact such as a mobile telephone number or email address. Reasonable requests will be accommodated.

iii) Family, Close Friends, Personal Representatives & Care Givers: Our staff may disclose to person involved in your care your PHI relevant to that person's involvement in your care or payment of the services providing you identify these individual(s) and authorize the release of information. If you are unable to agree or object to such disclosure, we may disclosure such information as necessary if we determine that it is in your best interest based on our professional judgment. If a young adult age eighteen (18) requests that his or her information not be released to a parent or guardian, we must comply with this request in compliance with state law. For minor children living in divided households, both parents (mother and father) have access to the PHI unless their parental rights have been terminated. Payment of services is addressed in your Final Divorce Decree; however, we obtain payment from the parent who brings the child in for treatment. We will provide you a statement to send to the other parent for your reimbursement.

iv) Emails: Email and other electronic forms of communication may not be encrypted. Such email may compromise the security of your PHI. If you elect alternative forms of communication, please notify our office.

v) Disaster Relief: If applicable, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

2. YOUR RIGHTS. The following is a statement of your rights regarding PHI we gather about you:

A) Copy of this Notice: You have the right to a copy of this notice including a paper copy.

B) Inspect and Copy PHI: You have the right to inspect and obtain a copy of PHI about you maintained by our Practice to include dental and billing records. You must submit a written request and indicate whether you prefer a paper or electronic copy. According to state and federal law, we may charge you a reasonable fee to copy your records. Our Practice does not transmit unsecure PHI via email. However, if you prefer this information emailed to you with encryption or security measures, we will comply with your request and will verify your email address. We suggest sending our Practice an email and we will reply with the attachment. (Note: Under federal law, you may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding. Please contact the Privacy Officer for more details).

C) Amendment: You have the right to have your provider amend your PHI about you in a designated record set. Please consult with the Privacy Officer. We may deny this request and you may respond with a statement. We may include a rebuttal statement in your record. Reasons we may deny amending such information, but not limited to these reasons, is if we did not create the information, or if the individual who created the information is no longer available to make the amendment or it is not part of the information maintained at our Practice.

D) Restrictions: You have the right to request a restriction of your PHI. If you paid out-of-pocket for a service or item, you have the right to request that information not be disclosed to a health plan for purposes of payment or health care operations and we are required to honor that request. You may request in writing to our Privacy Officer not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations such as to family members or friends involved in your care or for notification purposes as described in this Notice of Privacy Practices. However, your provider is not required to agree to this restriction. You may discuss restrictions with the Privacy Officer.

E) Confidential Communications: You have the right to request to receive confidential communications from our Practice by alternative means or at an alternative location. For example, you may prefer our Practice to use your mobile telephone or email rather than a residential line. Please make this request in writing to the Privacy Officer. Our staff will not ask personal questions regarding your request.

F) Disclosures: You have the right to request an accounting of disclosures of your PHI including those made through a Business Associate as set forth in CFR 45 § 164.528. The HITECH Act removed the accounting of disclosures exception to PHI to carry out treatment, payment and healthcare operations if such disclosures are made through the HER. To request an accounting, you must submit your request in writing to the Privacy Officer.

G) Breach Notification: According to the HITECH Act, you have the right to be notified following a breach of unsecured PHI that affects you. "Unsecured" is information that is not secured through the use of technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable and undecipherable to unauthorized users. Breach notification applies to our Business Associates who are obligated to notify our Practice if a breach of unsecured PHI occurs that affects you.

H) Fundraising: If PHI is used for fund raising which is considered "health care operations," basic requirements must be satisfied to include notice to the individual and a process for individuals to opt-out. If the individual consents, only specific parts of PHI may be used for fund raising. Note: Your PHI will not be used in this manner at our Practice.

3. Complaints: You have the right to file a complaint if you believe your privacy rights or that of a not her individuals' have been violated. You may contact our Privacy Officer and your issue will be addressed. You may also file a complaint with the Secretary of Health and Human Services at: U.S. Department of Health & Huma n Services, Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C. 20201. Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail; name the covered entity or business associate involved and describe the acts or omissions you believe violated the requirements of the Privacy, Security, or Breach Notification Rules; and be filed within 180 days or as determine d by this State when you knew that the act or omission complained of occurred. You may visit the Office of Civil Rights website at www.hhs.gov/ocr/hipaa/ for more information.

If you have any questions, would like additional information or want to report a problem regarding the handling of your PHI, you may contact the Privacy Officer at:

GROVE PARK DENTAL GROUP, PLLC
4515 POPLAR AVE, SUITE 406, MEMPHIS, TN 38 11 7
(901) 683-9800

You will not be penalized for filing a complaint

Additionally, you may file a complaint with the Secretary of Health and Human Service at:

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Room 515 FHHH Building
Washington, DC 20 201
www.hhs.gov/ocr