Luke Webster, DMD
Aksana Marshall, DMD
820 Love Avenue, Suite A
Tifton, GA 31794

PEDIATRIC DENTAL CENTER OF GEORGIA

Phone: (229)238-3787
Fax: (229)238-2530
frontoffice@pdctifton.com
www.pdctifton.com

Patient Information and Health History Form

Thank you for choosing Pediatric Dental Center of Georgia for your child's dental care!

Patient Information

Patient Name: _____ Name to be called: _____
First Middle Last
Date of Birth: _____ SSN: _____ Gender: ☐ Male ☐ Female
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Mom's Cell: _____ Dad's Cell: _____
Hobbies and Interests: _____
Who may we thank for referring you to us? _____

Parent Information

Guardian I

Name: _____ Date of Birth: _____ SSN: _____
Relationship to Patient: ☐ Mother ☐ Father ☐ Grandparent ☐ Other _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____ Email Address: _____
How may we contact you? (check all that apply): ☐ Email ☐ Text ☐ Cell Phone ☐ Home Phone
Check box if mailing address is the same as the patient's listed above. ☐
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Employer: _____ Work Phone: (____)_____-_____ ext._____

Guardian II

Name: _____ Date of Birth: _____ SSN: _____
Relationship to Patient: ☐ Mother ☐ Father ☐ Grandparent ☐ Other _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____ Email Address: _____
How may we contact you? (check all that apply): ☐ Email ☐ Text ☐ Cell Phone ☐ Home Phone
Check box if mailing address is the same as the patient's listed above. ☐
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Employer: _____ Work phone: (____)_____-_____ ext._____

Who has LEGAL custody? ☐ Guardian I & II ☐ Guardian I ☐ Guardian II ☐ Other: _____
Who does the patient live with? ☐ Guardian I & II ☐ Guardian I ☐ Guardian II ☐ Other:_____
Person responsible for payment of account: _____

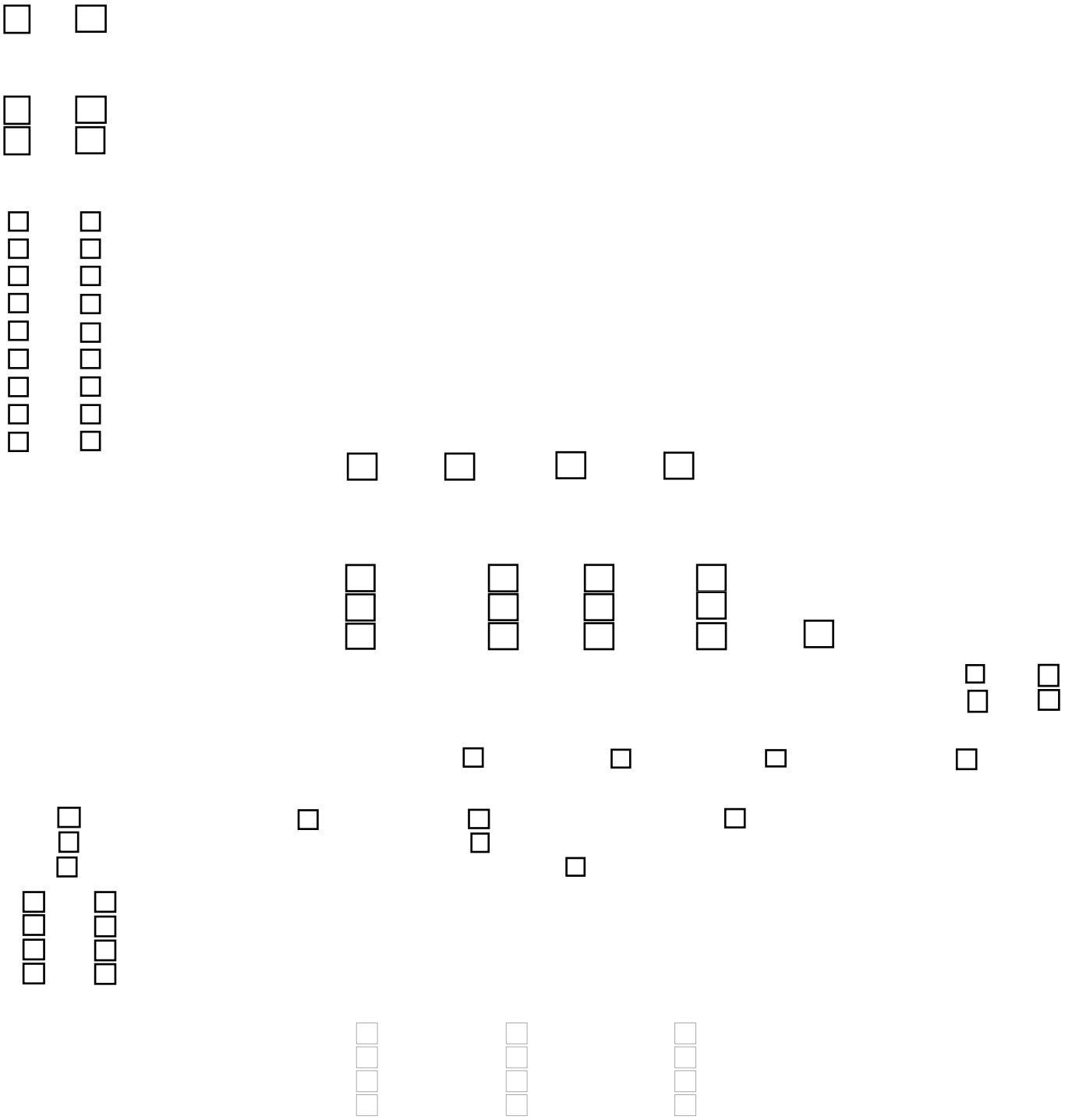
Dental Insurance Information

Primary Coverage

Policy Holder: _____ Relationship to Patient: _____
Policy Holder's Date of Birth: _____ SSN: _____
Insurance Company: _____ Insurance Company Phone: (____)_____-_____
Employer: _____
Group or Policy Number: _____ Member ID Number: _____

Secondary Coverage

Policy Holder: _____ Relationship to Patient: _____
Policy Holder's Date of Birth: _____ SSN: _____
Insurance Company: _____ Insurance Company Phone: (____)_____-_____
Employer: _____
Group or Policy Number: _____ Member ID Number: _____



Patient Name: _____

Medical History

Child's Physician/Pediatrician: _____ Phone Number: (____)_____-_____
Mailing address: _____ City: _____ State: _____ Zip code: _____

1. ☐Yes ☐ No Is your child in good health? Date of last physical exam: _____
   If no, please explain: _____
2. ☐Yes ☐ No Are your child's immunizations current? If no, list reason: _____
3. ☐Yes ☐ No Is your child currently taking any prescription medications?
   If yes, please give name, reason & date started: _____
   _____
4. ☐Yes ☐ No Is your child currently taking any over the counter medications?
   If yes, please give name, reason & date started: _____
   _____
5. ☐Yes ☐ No Is your child currently taking any vitamins or dietary supplements?
   If yes, please give name, reason & date started: _____
   _____
6. ☐Yes ☐ No Has your child ever been hospitalized, had surgery and/or general anesthesia?
   If yes, please list date and explain: _____
   _____
7. ☐Yes ☐ No Has your child ever been treated in an emergency room?
   If yes, please list date and explain: _____
   _____
8. Please check if your child has been diagnosed and/or treated for any of the following (check all that apply):

☐ ADD/ADHD	☐ AIDS/HIV	☐ Anemia	☐ Asthma
☐ Autism	☐ Bladder Issues	☐ Bleeding Issues	☐ Cancer/Tumors
☐ Cerebral Palsy	☐ Cleft Palate	☐ Chicken Pox	☐ Diabetes
☐ Drug/Alcohol Abuse	☐ Epilepsy or Seizures	☐ Fainting Spells or Dizziness	☐ Headaches
☐ Heart Murmur	☐ Heart Valve Replacement	☐ Hepatitis	☐ Hemophilia
☐ Kidney/Stomach Problems	☐ Learning Disability	☐ Lung Disease	☐ Measles
☐ Mumps	☐ Radiation/Chemotherapy	☐ Reflux	☐ Rheumatic Fever
☐ Scarlet Fever	☐ Sickle Cell Disease	☐ Sinus Trouble	☐ Skin Disorder
☐ Speech Problem	☐ Thyroid Disease	☐ Tuberculosis	☐ Other: (Comment Below)

   Comment(s): _____
9. ☐Yes ☐ No Has your child ever had any serious illness not listed above? If yes, please explain: _____
   _____
10. Please list all known allergies for your child: ☐Penicillin/Amoxicillin ☐Latex ☐Aspirin ☐Sulfa ☐ Metal
    ☐Local Anesthetic ☐Codeine ☐Food Allergies (List) _____ ☐ Other (List): _____
11. ☐Yes ☐ No Does your child have any handicaps or disabilities? If yes, please explain: _____
12. Has your child ever been evaluated by a specialist? If yes, please list:
    1. Name:_____ Specialty: _____ Phone (____)_____-_____
    2. Name:_____ Specialty: _____ Phone (____)_____-_____
13. ☐Yes ☐ No Is there any other significant medical history **pertaining to your child or his/her family** that the dentist should be told? If yes, describe: _____
    _____

I affirm that the information above is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health and it is my responsibility to inform the licensed professionals and staff of Pediatric Dental Center of Georgia, LLC of any changes in my child's medical status.

Legal Guardian Name (PRINT): _____ **Date:** _____

Legal Guardian Signature: _____

PEDIATRIC DENTAL CENTER OF GEORGIA

Consent for Dental Treatment

I am the parent or legal guardian of the minor child _____ and I warrant I have the authority to execute this document. There are no court orders now in effect that prevent me from signing this consent. I do hereby request and authorize the licensed professionals and staff of Pediatric Dental Center of Georgia, LLC to perform any necessary dental services on my child, including but not limited to, comprehensive examinations, cleanings, x-rays and photographs as necessary for diagnostic purposes, any necessary treatment and the administration of anesthetics that are deemed medically advisable by the licensed professionals and staff of Pediatric Dental Center of Georgia, LLC. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. The licensed professionals and staff of Pediatric Dental Center of Georgia, LLC will provide an environment that will help my child learn to cooperate during treatment including praise, explanations, demonstrations of procedures and instruments and using variable voice tones. I understand that these efforts to guide my child's behavior are for the safety of my child as well as the licensed professionals, staff and other patients of Pediatric Dental Center of Georgia, LLC.

In giving this consent for dental treatment, I am affirming that I have given the licensed professionals and staff of Pediatric Dental Center of Georgia, LLC full and complete disclosure of my authority to give this consent and have provided a complete history of my child's medical condition(s). I fully understand that the licensed professionals and staff of Pediatric Dental Center of Georgia, LLC are relying on the information I have provided in agreeing to treat my child. I understand it is my responsibility to inform the licensed professionals and staff of Pediatric Dental Center of Georgia, LLC of any personal or health information changes.

While the licensed professionals and staff of Pediatric Dental Center of Georgia, LLC will assist me in filing claims with third party payor(s), I understand I will be ultimately responsible for any charges incurred for the dental treatment rendered to my child, even if the third party payor(s) deny the claim(s) submitted.

I am aware that some or all of the health care professionals performing services at Pediatric Dental Center of Georgia, LLC are independent contractors and are not agents or employees. Independent contractors are responsible for their own actions and Pediatric Dental Center of Georgia, LLC shall not be liable for the acts or omissions of any such independent contractor.

I understand and agree that this consent shall remain in effect as long as my child is a patient of Pediatric Dental Center of Georgia, LLC or until the consent is terminated in writing or by operation of law.

Patient Name (PRINT): _____ **Date of Birth:** _____

Legal Guardian Name (PRINT): _____ **Date:** _____

Legal Guardian Signature: _____

PEDIATRIC DENTAL CENTER OF GEORGIA

HIPAA Patient Consent and Authorization Form

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your child's dental and medical records. Our benefits office (or other third parties designated by our office) may sometimes need to disclose dental, medical or payment information protected by HIPAA in relation to our group health plans to your child's family members or close friends involved in your child's health care. For example, your child's grandmother may need to contact us if your child needs a restorative procedure in order to determine whether the particular procedure is covered under our group health plan or may need assistance filing a claim for dental or medical services. Under HIPAA, unless you specifically object, we are allowed to use our professional judgment in deciding whether to discuss your child's dental, medical and payment information with your child's family members or close friends. However, we would like to provide you the opportunity to tell us with whom we may discuss your child's dental, medical or payment information under our group health plans.

Please choose one of the two options below

OPTION 1:

I do hereby authorize the licensed professionals and staff of Pediatric Dental Center of Georgia, LLC to discuss dental, medical and payment information for the patient listed below with the following named individual(s). I authorize the named individual(s) to bring my child to his/her dental appointments at Pediatric Dental Center of Georgia, LLC for treatment in my absence. I further expressly consent and authorize the individual(s) named to make dental and medical decisions for my child, including but not limited to, approving and/or authorizing any changes to the treatment plan, consenting to the use of restraint, and consenting to the use of nitrous oxide and/or oxygen inhalation sedation. Additionally, I expressly consent and authorize the individual(s) named to approve any changes to the financial estimate for services rendered. I understand and agree that I will ultimately be responsible for any charges incurred for the dental treatment rendered to my child.

	Authorized Patient Representative	Relationship to Patient
1.	_____	_____
2.	_____	_____
3.	_____	_____

I specifically request that no dental, medical or payment information be discussed with the following individual(s):

1. _____
2. _____

OPTION 2:

_____☐_____ I request the licensed professionals and staff of Pediatric Dental Center of Georgia, LLC to NOT DISCUSS any dental, medical or payment information with anyone other than the patient and myself (as patient's sole legal guardian).

By executing below, I hereby expressly release the licensed professionals and staff of Pediatric Dental Center of Georgia, LLC from any and all claims, actions, and/or liabilities of any kind related to my child's dental, medial or payment information being discussed and/or released to the above authorized individual(s) and for any treatment provided as a result of the authorization of these individuals. I understand this authorization will be in effect until such time as I change the person(s) referenced or revoke the consent by providing written notice to Pediatric Dental Center of Georgia, LLC.

Patient Name (PRINT): _____ **Date of Birth:** _____

Legal Guardian Name (PRINT): _____ **Date:** _____

Legal Guardian Signature: _____

Luke Webster, DMD • Aksana Marshall, DMD
Pediatric Dental Center of Georgia | 820 Love Avenue, Suite A • Tifton, Georgia 31794 | (229) 238-3787

PEDIATRIC DENTAL CENTER OF GEORGIA

Authorization for Release of Identifying Health Information

I authorize the licensed professionals and staff of Pediatric Dental Center of Georgia, LLC to release health information identifying my child [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. **Detailed description of the information to be released:** All records of treatment including insurance claims forms and Medicaid claims forms.

2. **To whom may the information be released:** Referring physicians, referral physicians and facilities, insurance companies, government agencies for claims purposes, those expressly authorized in writing by legal guardian(s), and persons/entities presenting a properly executed release of information.
   Other: _____

3. **The purpose(s) for the release:** At the request of the individual or for purposes of referral or claims processing.
   Other: _____

4. **Expiration date or event relating to the individual or purpose for the release:** Termination of the doctor/patient relationship between patient and the licensed professionals and staff of Pediatric Dental Center of Georgia, LLC.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat your child if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note to the office contact person listed at the bottom of this form telling us your authorization is revoked.

When your child's health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law, change this possibility.

By executing below, I acknowledge I have read and understand this form and am signing it voluntarily. I authorize the disclosure of my child's health information as described above.

Patient Name (PRINT): _____ **Date of birth:** _____

Legal Guardian Name (PRINT): _____ **Date:** _____

Legal Guardian Signature: _____

Office contact: Karlie Jones **Office contact email address**: practiceadmin@pdctifton.com

Luke Webster, DMD • Aksana Marshall, DMD
Pediatric Dental Center of Georgia | 820 Love Avenue, Suite A • Tifton, Georgia 31794 | (229) 238-3787

PEDIATRIC DENTAL CENTER OF GEORGIA

Office Policies

Thank you for choosing us as your child's pediatric dentist. We are committed to the successful treatment of your child's dental needs. Prior to any treatment being rendered, we require that you acknowledge in writing your receipt of this document and your understanding and agreement with the below policies.

Appointment Policy:

- We require at least 24 hours notification for appointment rescheduling or cancellation. This policy allows us to offer the appointment time to another child. There will be a $30 charge for a confirmed appointment which is missed or cancelled with less than 24 hours notice.
- Three (3) cancelled appointments with less than 24 hours notice or three (3) missed appointments will prevent further scheduling by our office.
- We **require verbal confirmation or electronic confirmation via text or email** to hold the patient's appointment. Otherwise, we will only be able to see the patient on a "fill in" basis.
- Our office is very busy. We may not be able to see a patient who arrives 5 minutes or more late, and should the patient not be treated on the date of their appointment, it will be counted as a missed appointment. If a patient arrives more than 5 minutes late, the legal guardian has the following options:
    - Option 1: Reschedule the appointment.
    - Option 2: Wait to be filled in during an opening on the same day. *There are no guarantees on this option.*
- Scheduling family members together is a courtesy we extend to our patients. However, patients from the same family who have missed a family appointment or cancelled a family appointment with less than 24 hours notice will not be allowed to schedule appointments together again.
- There are only a limited number of after school appointments. In order to be fair to all patients, we attempt to schedule one after school hygiene appointment a year. The other hygiene appointment must be in the morning. Keep in mind that missing school can be kept to a minimum when regular dental care is continued.
- From a behavioral standpoint, children age 5 and under respond better to treatment in the morning rather than the afternoon. Therefore, we strive to complete all restorative work for children age 5 and under before 1 p.m. each day.
- A legal guardian, or an individual previously authorized by the legal guardian in writing, must accompany the patient to each dental visit and remain at our office throughout the entire appointment.
- We understand emergencies happen, especially with children. We are happy to see our patients on an emergency basis, but we do require an appointment for an emergency. Please call us before coming to the office and we will fill the patient in as soon as possible. However, if the patient does not show for an emergency appointment, he/she will not be rescheduled as an emergency. The patient will be rescheduled at our first available appointment.
- If the dentist(s) recommends the patient undergo outpatient dental surgery but the patient's legal guardian chooses to forgo the recommended surgery the patient will be dismissed from the practice. We will see the patient on an emergency basis only for one month from the date of the surgery approval release.

Financial Policy:

Our staff is happy to assist you with your insurance questions. As a courtesy, we will file the patient's insurance claim. Please understand that we do not have a contract with the insurance company, only the insured does. It is therefore the insured's responsibility to correct any problem of payment with the insurance company. We are not responsible for what benefits are or are not paid on a claim. We can only assist you in estimating your portion of the cost of treatment. We are not responsible for any errors in filing your claim.

If a patient does not have dental insurance or is not eligible for dental insurance, then *payment in full is required on the day of service.* If a patient is retro-activated with their insurance, then our office will reimburse the insured once our office has been paid by the insurance company.

When patients are scheduled for operative appointments (i.e. sealants, fillings, nitrous oxide, etc.) we will estimate the patient's financial portion and *require the estimated amount to be paid on the day of service***.** We accept cash, check, or credit card (Visa or MasterCard). There will be a $30 fee if your check is returned.

You are responsible for any balance on your account after 30 days, whether insurance has paid or not. If you have not paid your balance within 60 days, a finance charge of 1.5% will be added to your account each month until paid (up to 18% annually). If you have not paid your balance within 90 days, we will be forced to send the account to a collection agency at which time a service charge may be added to the account balance.

Medical Photography Release/Approval:

Pediatric Dental Center of Georgia, LLC is dedicated to the use of the most advanced technologies available in giving and documenting your child's medical and dental care. To this end, we have invested in electronic medical records. This means that all items traditionally maintained in a paper format will be obtained, stored, and cataloged digitally. This record will also include digital photographs of your child(ren) for identification by our licensed professionals and staff. Any lesions, procedures, or other items which may be documented visually will also be stored and reproduced in this manner.

I hereby authorize the licensed professionals and staff of Pediatric Dental Center of Georgia LLC to obtain and reproduce photographs of my child(ren)'s likeness(es) for purposes of medical records. I also approve the use and reproduction of clinical photos for referral, coding, charting, marketing, advertising, and educational purposes.

By executing below, I acknowledge I have read and understand the Office Policies for Pediatric Dental Center of Georgia, LLC and will comply with same.

Patient Name (PRINT): _____ **Date of Birth:** _____

Legal Guardian Name (PRINT): _____ **Date:** _____

Legal Guardian Signature: _____

Notice of Privacy Practices

Pediatric Dental Center of Georgia, LLC

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/19, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOUR CHILD

We may use and disclose your child's health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your child's health information for treatment. For example, we may disclose your child's health information to a specialist providing treatment to your child. We may call or write to remind you of your child's scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help your child. Unless you tell us otherwise, we will mail, e-mail and/or text message you an appointment reminder and/or leave you a reminder message on your home or cell phone voicemail or with someone who answers your phone if you are not home.

Payment. We may use and disclose your child's health information to obtain reimbursement for the treatment and services your child receives from us or another entity involved with your child's care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your child's health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Child's Care or Payment for Your Child's Care. We may disclose your child's health information to your family or friends or any other individual identified by you when they are involved in your child's care or in the payment for your child's care. Additionally, we may disclose information about your child to a patient representative. If a person has the authority by law to make health care decisions for your child, we will treat that patient representative the same way we would treat your child with respect to your child's health information.

Disaster Relief. We may use or disclose your child's health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your child's health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your child's health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your child's PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your child's PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your child's PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your child's PHI in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to

tell you about the request or in situations deemed warranted by counsel to obtain an order protecting the information requested.

Research. We may disclose your child's PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your child's information.

Coroners, Medical Examiners, and Funeral Directors. We may release your child's PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your child's PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Child's Health Information Rights

Access. You have the right to look at or get copies of your child's health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your child's health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your child's health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your child's PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your child's health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have on file.

Amendment. You have the right to request that we amend your child's 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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if you disagree with a decision we made about access to your child's health information or in response to a request you made to amend or restrict the use or disclosure of your child's 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.

Our Privacy Official: Karlie Jones

- **Telephone:** 229.238.3787
- **Fax:** 229.238.2530
- **E-mail:** practiceadmin@pdctifton.com
- **Address:** Pediatric Dental Center of Georgia
  820 Love Avenue, Suite A
  Tifton, GA 31794

By executing below, I acknowledge I have received a copy of Pediatric Dental Center of Georgia, LLC's Notice of Privacy Practices.

Patient Name (PRINT): _____ **Date of Birth:** _____

Legal Guardian Name (PRINT): _____ **Date:** _____

Legal Guardian Signature: _____