DENTAL CARE
of FRISCO

BY THOMAS B. GRANT, DMD, PLLC

PATIENT INFORMATION

Date: _____ ☐ NEW PATIENT ☐ UPDATE

Patient: _____

LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐ CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

_____
PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

_____
SCHOOL / LOCATION

Patient Date of Birth: _____ Patient SSN: _____

Address: _____
ADDRESS LINE 1

_____
ADDRESS LINE 2

_____
CITY ST ZIP CODE

HOME: _____
CELL: _____
OTHER: _____
PAGER: _____
FAX: _____

E-Mail: _____

Referral? ☐YES ☐NO REFERRED BY: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address

_____ Tel: _____
NAME RELATIONSHIP

INSURANCE INFORMATION

Subscriber: _____
LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: _____ Subscriber SSN: _____

Subscriber Employer: _____

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER: _____

Group / Policy No.: _____ ID#.: _____

Address: _____ TEL: _____

_____ TOLL-FREE: _____

_____ FAX: _____
CITY ST ZIP CODE

SECONDARY INSURANCE CARRIER: _____

Group / Policy No.: _____ ID#.: _____

Address: _____ TEL: _____

_____ TOLL-FREE: _____

_____ FAX: _____
CITY ST ZIP CODE

3031 Preston Rd. | Suite 500 | Frisco, TX 75034 | **214.436.5122** | 214.436.5118 fax

www.dentistfrisco.com | info@dentistfrisco.com

DENTAL CARE
of FRISCO

BY THOMAS B. GRANT, DMD, PLLC

PRIMARY PHYSICIAN INFORMATION

Physician: _____ **Telephone:** _____

Clinic: _____

MEDICAL HISTORY

GENERAL HEALTH ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

☐Y ☐ N Under a physician's care now?
☐Y ☐ N Any hospitalization in the past 5 years? _____
☐Y ☐ N Any serious illnesses / surgeries? _____
☐Y ☐ N Use tobacco in any form? If Yes, Type: _____
☐Y ☐ N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y ☐ N Taking any prescription or daily OTC medications / drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y ☐ N Currtently nursing? ☐Y ☐ N Currently pregnant? Due Date: _____

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y ☐ N
If yes, please describe:

_____

Is there anything important about your medical condidtion we have not asked? ☐Y ☐ N If yes, please describe:

_____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ANGINA
☐ ALZHEIMER'S DISEASE
☐ AIDS/HIV CIRCLE
☐ ANEMIA
☐ ANAPHYLAXIS
☐ ANXIETY
☐ ARTIFICIAL HEART VALVE
☐ ARTIFICIAL JOINTS
☐ ARTHRITIS
☐ ASTHMA
☐ BREATHING PROBLEMS
☐ BLOOD DISORDER
☐ BLOOD TRANSFUSION
☐ CANCER
☐ CHEMO THERAPY
☐ CHEST PAINS
☐ COLD SORES
☐ CONVULSIONS
☐ CONGENITAL HEART DISORDER
☐ CORTISONE MEDICATION
☐ DIABETES
☐ DIZZINESS / FAINTING
☐ EPILEPSY/SEIZURES
☐ FREQUENT HEADACHES
☐ EMPHYSEMA
☐ EXCESSIVE BLEEDING
☐ GLAUCOMA
☐ HEART MURMUR
☐ HEPATITIS A, B OR C (CIRCLE)
☐ HIGH BLOOD PRESSURE
☐ HEART ATTACK/DISEASE
☐ KIDNEY/LIVER DISEASE
☐ HEART PACEMAKER
☐ EXCESSIVE THIRST
☐ MITRAL VALVE PROLAPSE
☐ HIGH CHOLESTEROL
☐ PSYCHIATRIC TREATMENT
☐ RADIATION
☐ RESPIRATORY DISEASE
☐ RHEUMATIC FEVER
☐ SINUS PROBLEMS
☐ STROKE
☐ THYROID CONDITION
☐ TUBERCULOSIS
☐ ULCERS
☐ VENEREAL DISEASE/STD
OTHER: _____

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ ASPIRIN
☐ ANESTHETIC-LOCAL
☐ BARBITURATES
☐ OTHER - PLEASE LIST _____
☐ CODEINE
☐ DAIRY
☐ LATEX
☐ LACTOSE INTOLLERANCE
☐ METAL SENSITIVITY
☐ NITROUS OXIDE SEDATION
☐ SLEEPING PILLS
☐ SULFA DRUGS
☐ PENICILLIN/OTHER ANTIBIOTICS
☐ NONE

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ANTIBIOTICS/SULFA DRUGS
☐ BLOOD THINNERS
☐ INSULIN
☐ OTHER DIABETIC MEDICATIONS
☐ OTHER (PLEASE LIST BELOW)
☐ ANTIHISTAMINES/ALLERGY
☐ CANCER/CHEMO MEDICATIONS
☐ NITROGLYCERIN
☐ RECREATIONAL DRUGS
☐ DAILY ASPIRIN
☐ CORTISONE/STEROIDS
☐ ORAL CONTRACEPTIVES
☐ THYROID MEDICATIONS
☐ BLOOD PRESSURE MEDS
☐ HEART MEDICATION/DIGITALIS
☐ OSTEOPOROSIS MEDICATIONS
☐ TRANQUILIZERS

DRUG NAME	DOSAGE	REASON PRESCRIBED

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DENTAL HISTORY

ORAL HEALTH ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Date of Last Dental Visit: _____

Treatment Type: _____

Would you like to have a VisiLite oral cancer screening? ☐ YES ☐ NO

**Note: Some insurance plans do not cover this service; please check your plan documents for details.*

☐Y ☐ N Are you currently having dental discomfort? If yes, explain: _____

☐Y ☐ N Any unhappy / unpleasant dental experiences? If yes, explain: _____

☐Y ☐ N Any injuries to mouth / teeth / head? If yes, Explain: _____

☐Y ☐ N Any missing teeth other than wisdom teeth or orthodontic extractions?

☐Y ☐ N Have missing teeth been replaced?

☐Y ☐ N Orthodontic appliances now or in the past?

☐Y ☐ N Gums bleed when brushing or flossing?

☐Y ☐ N Concerned about gum disease? History of gum disease? ☐Y ☐ N

☐Y ☐ N Any concerns about the appearance of your teeth?

☐Y ☐ N Does it hurt to bite or chew?

☐Y ☐ N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y ☐ N

☐Y ☐ N Do you want to become a regular continuing care patient in our practice?

☐Y ☐ N Do you want your mouth properly restored and pain free?

☐Y ☐ N Does any type of dental treatment make you nervous? If yes, please explain below:

_____

The most important concerns regarding my dental treatment are:

_____

What factors are most important for your satisfaction with our office?

_____

Any additional concerns / comments?

_____

Please Read prior to filling out Medical History:

Although dental personnel primarily treat in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.
Than you for thoroughly answering the following questions.

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Patient's Name: _____

Address: _____

Telephone Number: _____ Email Address: _____

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. Please ask for a copy if you chose to do so. 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. We encourage you to read it completely before signing this document.

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 obtain.

You may obtain a copy of Notice of Private Practices, including any revisions, at any time by contacting:
Telephone: 214.436.5122 **Fax:** 214.436.5118 **Email:** info@dentistfrisco.com
Address 3031 Preston Road, Suite 500, Frisco, TX 75034

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

Signature: _____ **Date:** _____

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

Guardian/Personal Representative Name: _____

Relationship to Patient: _____

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

Right to revoke: You will have the right to revoke this consent at any time by giving us written notice of 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.

REVOCATION OF CONSENT:
I revoke my Consent for you and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of Consent will not affect any action you took in reliance on this Consent before you received my revocation, and that you may decline to treat me or to continue treating me if I have revoked this consent.

Signature: _____ **Date:** _____

DENTAL CARE
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Financial Guidelines / Office Policies

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines. We ask that you provide us with any changes to your insurance no later than 48 hours prior to your appointment.

Insurance

We accept all major PPO dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

- **Minors must be accompanied by parent or legal guardian.** If the parents are separated or divorced, the person accompanying the minor will be responsible for co-payment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.

- **Payment Information:**
  - All major credit cards are accepted (Visa, MasterCard, Discover American Express)
  - 10% discount for Senior Citizens
  - 5% Cash Discount when paid in full
  - Various financing options with CareCredit®

- **Balances left over 90 days will begin going through the process of collections:** 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.

Short Cancelled / Missed Appointments

When your appointment is made, a room is reserved, your records are prepared and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We ask that if you must change an appointment, you give at least 48 hours notice. This makes it possible to give your reserved room to another patient.

There is a charge for not showing up to your appointment.
Repeated cancellations or missed appointments will result in loss of future appointment privileges.

By signing below, I acknowledge I have read and understand the guidelines above.

Signature: _____ **Date:** _____

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DENTAL CARE
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Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patients.

Our policy is as follows:

We require that you give our office **48 hours'** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. **A fee of $40 per hour for hygiene appointments and $75 for the first hour and $50 each additional hour for doctors' appointments will be charged to you: This fee cannot be billed to your insurance company and will be your direct responsibility.** No future appointments can be scheduled without the payment of this fee.

Additionally, if a patient is more than 15 minutes late without prior notice for a scheduled appointment, we will consider this as a missed appointment and the appropriate cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by it's terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of Dental Care of Frisco Appointment Cancellation Policy.

_____

Signature of Patient Date

FAMILY & COSMETIC DENTISTRY

3031 Preston Rd. | Suite 500 | Frisco, TX 75034 | **214.436.5122** | 214.436.5118 fax

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Dental Care of Frisco

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****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}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____	_____
{Please Print Name}	Relationship
_____	_____
{Please Print Name}	Relationship
_____	_____
{Please Print Name}	Relationship

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)

_____

_____

_____

Dental Care of Frisco

Date _____

Our office is now able to send email and text messages to patients to confirm appointments! This is a great tool for our patients to utilize when a phone call isn't possible. However, we understand some patients prefer to simply be called.

Please indicate below if you would like to receive email and text message appointment confirmation and reminders from our office. If so, please provide your cell phone number and/or email address. As always, we will never share your cell phone and email information with any 3rd party companies.

- ❑ Yes, I would like to receive a text message confirmation.
- ❑ No, please do not text me regarding my appointments.

Cell phone number _____

- ❑ Yes, I would like to receive email appointment confirmations.
- ❑ No, please do not email me regarding my appointments.

Email address _____

Printed Name _____

Signature _____

Parent/Guardian _____

Please check any additional information you would like to receive via email/text.

Newsletters ☐

Promotions ☐

Now you can view your appointments and make payments on-line. To learn more go to www.SmileDash.com.

NOTICE OF PRIVACY PRACTICES
THOMAS B. GRANT, DMD, PLLC

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 September 1, 2012, and will remain in effect until we replace it. We may change our privacy practices from time to time. If we do, we will revise this Notice so you will have an accurate summary of our practices. The revised Notice will apply to all of your health information. We may also revise this notice from time to time. If we make any material revisions to this Notice, we will provide you with a copy of the revised Notice which will specify the date on which such revised Notice becomes effective. We are required to abide by the terms of the Notice that is currently in effect. 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

A. Use and Disclosure for Treatment, Payment, and Health Care Operations

We must disclose your health information to you, as described in the Patient Rights section of this Notice. We also use and disclose health information about you, in electronic or other format as needed, for treatment, payment, and health care operations. For example:

- **Treatment:** We may disclose your health information to a physician or other health care provider providing treatment to you.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **Health Care Operations:** We may use and disclose your health information in connection with our health care operations, including quality assessment and improvement activities, review of the competence or qualifications of health care professionals, evaluation of practitioner and provider performance, training programs, accreditation, certification, and licensing and credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or health care 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.

Disclosures To Your Family and Friends: We may disclose your health information to a family member, friend, or other person identified by you to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Disclosures To Persons Involved in Your Care: We may also 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, 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 use or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, and we will disclose only health information that is directly relevant to the person's involvement in your health care. 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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemails, postcards, letters, e-mails, texts or other similar mobile device communications).

Patient-Related Communications: We may use or disclose your health information to provide patient-related communications such as intraoral photography, "no cavity club" for children, and telephoned-in prescriptions.

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

B. Use and Disclosure for the Public Need

In particular situations involving the public need, we may disclose your health information without obtaining your authorization. Those situations include the following circumstances:

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

Public Health Activities: We may disclose your health information to authorized public health officials so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury, or disability.

Health Oversight Activities: We may release your health information to government agencies authorized to conduct audits, investigations, and inspections as well as civil, administrative or criminal investigations, proceedings, or actions.

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.

Product Monitoring, Repair and Recall: We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products, or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits And Disputes: We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other disputes. We may also disclose your health information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

Law Enforcement: We may disclose your health information to law enforcement officials for certain reasons including to comply with court orders or laws that we are required to follow, and to assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person.

(5-14) Daniell The Printer, Inc.
Winchester, Tennessee

To Avert a Serious and Imminent Threat to Health or Safety. 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. In such cases, we will only share your information with someone able to help prevent the threat.

National Security: We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may also disclose to military authorities the health information of Armed Forces personnel under certain circumstances. If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined.

Coroners, Medical Examiners and Funeral Directors. In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

C. Partially De-Identified Health Information

We may use and disclose "partially de-identified" health information about you for public health and research purposes, or for business operations, if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will not contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. If we maintain your health information in electronic format, you may request a copy of your information in electronic format and we will charge you no more than our cost of preparing the materials. If we maintain your information in paper files, you may request photocopies or copies in other format. We will use the format you request unless we cannot practically and reasonably do so. If you request an alternative format, we may charge a cost-based fee for providing your health information in that format. 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.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years or such shorter time as you may specify. That accounting would not include disclosures made for the purposes of treatment, payment, or health care operations, unless we maintain your health record electronically, in which case, after January 1, 2011, we may need to provide you with an accounting of treatment, payment, or health care operations disclosures for no more than 3 prior years, but not including any treatment, payment or health care operations disclosures prior to January 1, 2011. 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.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. If we agree to your request, we will abide by our agreement except in an emergency situation. However, we are not required to agree to these additional restrictions, except that we must agree to a request that we restrict disclosure of your information to a health plan for purposes of payment or health care operations if the information pertains solely to a health care item or service that you have paid for out of pocket and in full.

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 a satisfactory explanation regarding how payment will be handled under the alternative means or location you request.

Amendment of Health Information: 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.

Notification of Breach of Unsecured Health Information: Our policy is to encrypt our electronic files containing your health information so as to protect the information from those who should not have access to it. If, however, for some reason we experience a breach of your unencrypted health information, we will notify you of the breach.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you have the right to request a paper copy of this Notice. You may make such a request by writing to the address provided at the end of this Notice.

OTHER SPECIFIC STATE LAW REQUIREMENTS

Texas provides you the right to restrict the disclosure of HIV/AIDS related information and to limit the circumstances in which we may disclose HIV/AIDS related information except to agencies involved in collecting relevant data or as otherwise permitted or required by applicable law. We must also obtain your consent before disclosing your genetic information except pursuant to a court order or legal proceedings, to determine paternity or as otherwise permitted or required under applicable law.

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.

CONTACT INFORMATION
Thomas B. Grant DMD, PLLC
3031 Preston Road, Ste 500
Frisco, TN 75034