TIME 03:14 PM DATE 3/6/2017

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

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

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

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

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

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

Birth Date: Age: Soc Sec: Drivers Lic:

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

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

PHARMACY LOCATION

Primary Insurance Information

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

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

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

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

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

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

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

Rem. Benefits: Rem. Deduct:

Time 10:07 AM | Cynthia L. Graves DDS LTD., LLP | Date 10/15/2015

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

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

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

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

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

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

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

PATIENT DENTAL HISTORY

PATIENT NAME _____

PATIENT ACCOUNT NO. _____ MEDICAL ALERT _____

	YES	NO
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
4. Do you feel pain in any of your teeth?	❑	❑
5. Do you have any sores or lumps in or near your mouth?	❑	❑
6. Have you had any head, neck or jaw injuries?	❑	❑
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	❑	❑
b) Pain (joint, ear, side of face)?	❑	❑
c) Difficulty in opening or closing?	❑	❑
d) Difficulty in chewing?	❑	❑

	YES	NO
8. Do you have frequent headaches?	❑	❑
9. Do you clench or grind your teeth?	❑	❑
10. Do you bite your lips or cheeks frequently?	❑	❑
11. Have you ever had any difficult extractions in the past?	❑	❑
12. Have you had any orthodontic work?	❑	❑
13. Have you ever had prolonged bleeding following extractions?	❑	❑
14. Have you ever had instruction on the correct method of brushing your teeth?	❑	❑
15. Have you ever had instructions on the care of your gums?	❑	❑

What is the reason for your visit today? _____

_____

Date of last dental visit _____

What was done at your last dental visit? _____

_____

Do you have any dental problems now? YES NO

If yes, please describe: _____

_____

Are you satisfied with the appearance of your teeth? YES NO

What would you change about your smile? _____

Do you brush, floss or use any other dental aids? _____

Is there anything else about having dental treatment that you would like us to know? YES NO

If yes, please describe _____

Certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____

PATIENT, PARENT OR GUARDIAN DATE

Continued on back ➔

Cynthia L. Graves DDS

Beautiful Smiles, Exceptional Care

Photo and Film Release Form

Name: _____

Address: _____

Phone: _____

Email: _____

Date: _____

I agree to the inclusion of my contribution in promotional photos/videos for Cynthia L. Graves DDS (10418 Lake Creek Parkway Austin, TX 78750). The nature of these photos/videos has been explained to me.

I understand that content may be edited and there is no guarantee that my contribution will be included in the final product.

I agree that my contribution can and will be used to promote Cynthia L. Graves DDS including distribution and presence across the internet and has the potential to appear in other forms of advertising.

My contribution, to the best of my knowledge has been truthful and honest.

Signature: _____

Print Name: _____

Cynthia L. Graves DDS
Beautiful Smiles, Exceptional Care

10418 Lake Creek Pkwy
Austin, TX 78750
Office: (512) 258-8001
Fax: (512) 258-4106
www.cynthiagravesdds.com

RECORD RELEASE FORM

I, _____ hereby authorize
(Print Patient's Name)

_____
(dentist name, email & fax number)

to provide

Cynthia L. Graves DDS
10418 Lake Creek Pkwy
Austin, TX 78750
(512) 258-8001
Fax: (512)258-4106

With copies of my dental records with respect to any dental care and treatment

Signed: _____ Date: _____
(Patient)

Signed: _____ Date: _____
(Parent, legal guardian, or custodian if patient is a minor)

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Financial Policy for Patients with Insurance

Effective February 1, 2016.

In order to provide exceptional, personalized care, Dr. Graves does not participate as a "Network Dentist" on any Dental Insurance Plans. For most "Network Plans" we are allowed to file your insurance as an "Out of Network Provider". Because we bundle procedures that are often broken out as separate line-item charges (ex: sterilization fees, OSHA fees, oral hygiene instruction, periodontal exams), your total care needs with us should be comparable in out-of-pocket costs to many "In-Network" Practices in the area.

At the time of service, Patients with Dental Insurance are allowed to pay the amount of the estimated portion not covered by their Policy.

As a courtesy, our team will file insurance claim(s) electronically for you on the date of treatment. As it is anticipated that the balance will be paid from your Dental Benefits, we will have you sign an agreement for assignment of benefits so the payment can be sent directly to us. Should the Insurance Company insist on sending their check to you directly, you are expected to remit the balance to us within 10 calendar days.

Please understand that we have no control over your Dental Insurance Benefits. We subscribe to a service that assists us in determining an estimate of what your Dental Benefits may pay but, this is not a guarantee of payment by your Insurance Company.

In reality, Dental Insurance isn't really insurance (a payment to cover the cost of a loss). It is a financial benefit to help pay for routine Dental Care. In our experience, most Dental Benefits cover only a portion of our Patients' total care needs and are subject to either an annual cap and/or a downgrade in the recommended care to an option that is less costly. It is important for you to remember that the dental insurance coverage is a contract between you and the Insurance Company. That contract is based on actuarial studies, not your long-range personal clinical needs.

If your insurance benefit has not been paid within 90 days of when we file your claim, you will be asked to make payment for the balance owed on your account for that claim. In some cases, we can extend our services to continue to pursue the claim, but in many cases, the Patient is more successful in pursuing payment of the claim with their Insurance Company. Based on our experience, success in processing claims varies from plan to plan. If an insurance payment is issued to us after the 90-day period, and you have paid for the service/claim in full, we will initiate a refund to you within 5 business days.

In some cases, your Medical Insurance may provide coverage for specific treatment. At this time the covered services are limited to 3D Cone Beam Scans, Surgical Procedures and Treatment for Trauma. In these cases, we can process a medical claim for you. Due to the unpredictable nature of Medical Insurance reimbursement, we are unable to extend the same payment arrangements we provide for chargeable service as Dental Insurance.

Hopefully, we will experience an expansion of services that are covered by Medical Insurance in the future.

Cynthia L Graves, DDS Ltd LLP is NOT a Medicare or Medicaid provider.

My signature below indicates my understanding and acceptance of the terms related to Insurance Benefits as they relate to my account with Cynthia L Graves, DDS Ltd LLP.

I authorize payment to Dr. Graves as a designated assignment of benefits for Medical and Dental Insurance claims.

Printed Name	Signed	Date

Cynthia L. Graves DDS
Beautiful Smiles, Exceptional Care

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Austin, TX 78750
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Fax: (512) 258-4106
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Practice Financial Policy

Effective February 1, 2016.

Dental treatment is an investment in your overall health and personal appearance. When you receive a treatment proposal, please ask questions regarding the timing and priority of your treatment needs. Dr. Graves and her team will work to time your care in a way that fits best for you. Let us help you create a financial plan to achieve optimal health.

Financial Agreement

Payment is expected on the date and time of service unless specific arrangements have been made in advance and approved by Dr. Graves.

We accept cash, personal checks, VISA, MasterCard and American Express. We also offer the CareCredit program as a financing option. CareCredit terms vary and are subject to approval. If you are interested in this option, please discuss it further with one of our team members.

Optional Payment Terms and conditions:

1. ***Full Pay Cash Discount:*** We offer a 5% courtesy discount off services over $1,000.00 when paid in full by cash or check prior to or on the date and time of treatment.
2. ***Term Loan:*** By arrangement with CareCredit, Patients may be eligible for an interest-free loan for 6 to 18 months (based on individual terms with CareCredit).
3. ***Recurring payments:*** Recurring payments can be made to your credit card – please ask for details.
4. ***Returned Check Fee:*** You are responsible for a fee of $35.00 to us for any returned checks.

Delinquent Accounts

We understand that temporary financial situations arise that may affect the timely payment of your account. In this case, we ask you to contact us promptly to discuss the management of your account. *Most often financial misunderstandings can be handled with a simple phone call.*

Any account that is seriously past due is subject to referral to a third party collection agency and/or reporting to the IRS as a bad debt loss using IRS form 1099. Our goal is to avoid reaching this point in our relationship.

Failed Appointments

Because we reserve a specific block of time for each patient's personalized care, failed appointments (late cancellations or missed appointments) increase our operational costs and inconvenience other patients.

For this reason, we ask that you give us a MINIMUM of 24 hours' notice if you are unable to keep your appointment. We understand that unexpected situations arise from time-to-time but, after 3 failed appointments, we will place you on a "short notice" list. We use this list so we can schedule your appointment closer to the time of your next appointment, in hopes that your schedule is less likely to change.

Please indicate understanding and acceptance of these financial policies by signing below. For the mutual convenience of our patients, this executed copy of the Financial Policy shall cover you and any dependents who are Patients of the Practice.

Printed Name	Signed	Date

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HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY AND / OR FRIENDS

Patient Name _____ Date of Birth_____

Cynthia Graves DDS is authorized to release protected health information about the above named patient to the following listed person:

Name_____ Phone#_____ Relationship_____

Name_____ Phone#_____ Relationship_____

Name_____ Phone#_____ Relationship_____

APPROVED ROUTES OF COMMUNICATION TO PATIENT

Please indicate with Yes, No, or N/A for each situation giving us your authorization to communicate with <u>you</u> via:

_____Email _____Text Message _____ Voice Mail Message _____Phone Calls

Dr. Cynthia Graves may use the above routes to communicate the following information, please initial:

_____Scheduling _____Financial _____Medical & Dental Information

<u>RIGHTS OF THE PATIENTS</u>

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Dr. Cynthia Graves. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information released as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refused to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

_____

Signature of patient /Parent /Legal Guardian/Personal Representative Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ _____
Signature Date

CONSENT/RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

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

_____ _____
Signature Date

Cynthia L. Graves, DDS Ltd
LLP
10418 Lake Creek Parkway

Texas, 78750

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL 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 AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at Cynthia L. Graves, DDS Ltd LLP understand that medical information about you and your health is personal. Applicable federal and state law requires us 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 06/10/2016, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment For Services: We can use and disclose your health information to obtain payment for services we provide to you.

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

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

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

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for

your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

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

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

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

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

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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

PATIENT RIGHTS

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

of this Notice for a full explanation of our fee structure.)

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

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

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

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

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

QUESTIONS AND COMPLAINTS

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

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

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.

Privacy Officer: Cynthia Graves
Telephone: 5122588001
Fax: _____
E-mail: manager@cynthiagravesdds.com
Address: 10418 Lake Creek Parkway

Zip Code: 78750
State: Texas