Welcome to Texas Tooth Fairies Pediatric Dentistry

Pamela R. Singletary, DDS
Diplomat American Board of Pediatric Dentistry

ABOUT YOUR CHILD:

Legal Name:

____
First Middle Last

Nickname: ________________ Gender: Male/Female
Date of Birth: __________________ Age: _________
Home Address:

____
City: _____________________ Zip: ____________
Home Phone: _________________________________
Mom's Cell: _________________________________
Mom's Email: ________________________________
Dad's Cell: _________________________________
Dad's Email: ________________________________
Who Does Child Live With? ____________________
Primary Guardian: ____________________________
School: ____________________ Grade: __________
Brother(s)? __________________ Age(s): _________
Sister(s)? ___________________ Age(s): _________

Referral Information:
Whom may we thank for referring you to our practice?

____

ABOUT YOUR FAMILY:

Mother/Stepmother/Co-Parent/Guardian ____________
❑Married ❑Single ❑Divorced
Name: ____
First MI Last
Home Address (if different):

____
City: _________________________ Zip: __________
Home Phone (if different) _______________________
SS#: __________________ Date of Birth: __________
Employer: ______________ Occupation: ____________
Work Phone: ____________________

Father/Stepfather/Co-Parent/Guardian ____________
❑Married ❑Single ❑Divorced
Name: ____
First MI Last
Home Address (if different):

____
City: _________________________ Zip: __________
Home Phone (if different) _______________________
SS#: __________________ Date of Birth: __________
Employer: ______________ Occupation: ____________
Work Phone: ____________________

PRIMARY DENTAL INSURANCE:

Insurance Company: ___________________________
Insurance Phone#: ___________________________
Insurance Address:

____

____
Policy Holder: ________________________________
Relationship to Patient: _______________________
Employer: ____________________________________
D.O.B: ______________ SS#: ____________________
ID: ______________ Group#: ____________________

Internal Use: PPO/Traditional/Discount/XIX/No Ins

SECONDARY DENTAL INSURANCE (if applicable):

Insurance Company: ___________________________
Insurance Phone#: ___________________________
Insurance Address:

____

____
Policy Holder: ________________________________
Relationship to Patient: _______________________
Employer: ____________________________________
D.O.B: ______________ SS#: ____________________
ID: ______________ Group#: ____________________

Internal Use: PPO/Traditional/Discount/XIX/No Ins

Social History:

Does your child have problems with: ❑SPEECH ❑HEARING ❑VISION?
What type of learner is your child: ❑ADVANCED ❑PROGRESSING NORMALLY ❑SLOWER LEARNER
Child's First Language: ______________________ Second Language: ____________________________________
Child's Favorite: PET ____________________ TOY ____________________ COLOR ____________________
FRIEND ____________________ HOBBY ____________________

Patient Name: ____

First | Last | Nickname

Child's Physician: ___________________________ Phone# __________________When was the last visit? ___________________

- Is your child in general good health? **YES/NO**
- Are they up to date with Immunizations? **YES/NO**
- Is your child **allergic** or had any **adverse reaction** to a medication? **YES/NO**
  If YES, please Explain: ____
- Does your child have any additional **allergies** (i.e. Latex, Seasonal Allergies, Food Allergies, Drug Allergies)? **YES/NO**
  If YES please explain: ____
- Does your child have **breathing problems** or **asthma**? **YES/NO**
  Has your child been to the ER for an **Asthma Attack**? **YES/NO**
  What induces a **breathing problem**? ____
  What **Asthma Medication(s)** does your child take? ____
- Is your child taking any **medications**? **YES/NO**
  If YES, please list medications, dosage, and reason for medication: ____
  ____
- Does your child have any **physical disabilities**? **YES/NO**
  If YES, please explain____
- Does your child have any **developmental disabilities**? **YES/NO**
  If YES, please explain____
- Has your child ever had an **operation, been hospitalized or treated in an emergency room**? **YES/NO**
  If YES, please explain why and when: ____

MARK YES OR NO TO ALL OF THE FOLLWING:

YES/NO

❑ ❑ ADD/ADHD
❑ ❑ Autism Spectrum
❑ ❑ Sensory Integration Issues
❑ ❑ Nervous or Emotional Disorders
❑ ❑ Eating Disorders
❑ ❑ Mental/Emotional Problems
❑ ❑ Heart Trouble or Heart Murmur
❑ ❑ Rheumatic Heart Disease or Fever
❑ ❑ Blood Disease or Anemia
❑ ❑ Abnormal Bleeding or Bruising
❑ ❑ Prolonged Bleeding or Transfusion
❑ ❑ Von Willebrand/Hemophilia
❑ ❑ High or Low Blood Pressure

YES/NO

❑ ❑ Cancer, Tumors, Growths or Cysts
❑ ❑ Steroid Therapy or Chemotherapy
❑ ❑ Diabetes
❑ ❑ Kidney Disease
❑ ❑ Liver Disease
❑ ❑ Hepatitis or Jaundice
❑ ❑ Thyroid Disease
❑ ❑ HIV or AIDS
❑ ❑ Herpes virus or Shingles
❑ ❑ Latex Allergy/Sensitivity
❑ ❑ Birth Defect(s)
❑ ❑ Cleft Lip or Palate
❑ ❑ Cerebral Palsy Pressure
❑ ❑ Downs Syndrome
❑ ❑ Tuberculosis or TB Exposure

YES/NO

❑ ❑ Frequent Diarrhea or Vomiting
❑ ❑ Ear, Eye, Nose Throat Trouble
❑ ❑ Sinus Problems or Drainage
❑ ❑ Hearing or Vision Impairment
❑ ❑ Epilepsy/ Convulsions/Seizures
Date of Last Seizure_____________
❑ ❑ Problems with anesthesia
❑ ❑ Mumps/Measles/Chickenpox
❑ ❑ Scarlet Fever/High Fever
❑ ❑ Stomach Ulcers
❑ ❑ Pregnant
❑ ❑Other_____________________

Dental History:

Last visit to a Dentist (Date):_________________________________Dentist's Name:_____________________________________

Has your child complained about **dental problems**: **YES/NO** If YES, please explain:____

Does your child have any history of the following **dental issues**: (Check ALL that apply): ❑CAVITIES ❑TOOTHACHE ❑BLEEDING GUMS ❑TMJ POPPING ❑DISCOLORED TEETH ❑SENSITIVITY TO HOT/COLD/SWEETS

Has your child had any history of the following **habits**: (Check ALL that apply):
❑THUMBSUCKING ❑FINGERSUCKING ❑LIP BITING ❑NAIL BITING ❑PACIFIER USE ❑EXCESSIVE BOTTLE USE

History of **injuries** to Mouth/Teeth/Head? **YES/NO** If YES, please explain:____

Does your child **brush** their teeth daily? **YES/NO** Number of Brushings?______________Floss Daily? **YES/NO**

Do you (Parent/Guardian) assist your child with brushing? **YES/NO**

Is **Fluoride** taken? **YES/NO**

Purpose of dental visit today:____

Describe how you believe your child will behave today (Check ALL that apply):
❑FRIENDLY ❑HAPPY ❑TIMID ❑AFRAID ❑RESISTANT

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 child's health. It is my responsibility to inform the dental office of any changes in my child's medial status. **Signature:** ____**Date:** ___________________

Relationship to patient: _______________________

TEXAS TOOTH FAIRIES PEDIATRIC DENTISTRY

PAMELA R.SINGLETARY, DDS

CONSENT FOR DENTAL PROCEDURES AND ACKNOWLEDGEMENT FOR RECEIPT OF INFORMATION

It is the policy of this dental practice to inform parents of all procedures contemplated for your child. At each examination appointment, we will identify any dental treatment needed and describe this to you and your child. Each regular examination visit consists of oral hygiene instructions, cleaning of the teeth, topical application of fluoride, radiographs (x-rays) if needed, examination of the teeth, examination of hard and soft tissues of the mouth and the bite. Any other treatment needed such as fillings, crowns, sealants, extractions, etc. will be performed at a separate appointment after obtaining your permission. No dental treatment will be performed without your knowledge.

State Law requires that we obtain your written informed consent for any treatment given your child as a legal minor.

Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain further.

1. I hereby authorize and direct Dr. Pamela R. Singletary assisted by other dentists and/or dental auxiliaries of her choice , to perform upon my child, the following dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.
2. In general terms the dental procedures or operations will include:
   A. Cleaning of the teeth and the application of topical fluoride.
   B. Application of plastic "sealants" to the grooves of the teeth
   C. Treatment of diseased or injured teeth with dental restoration (fillings or caps).
   D. Replacement of missing teeth with dental prosthesis.
   E. Removal (extraction) of one or more teeth.
   F. Treatment of malposed (crooked) teeth and/or oral development of growth abnormalities.
   G. Use of local anesthesia, by injection, to numb the teeth worked on. Numbness usually lasts from 1 ½-3 hours. Allergic reactions are rare. Your child will be cautioned not to bite the numb lip and cheek. Please do not tell your child that they are going to get a "shot." We have our special way to inform them of this.
   H. Use of behavior management techniques outlined on page 4.

I fully understand there is a possibility of surgical and/or medical complications developing during or after the procedure. These risks and side effects may include adverse reaction to a drug that may cause necessary hospitalization, further surgical procedures, disability, system impairment, permanent or temporary nerve damage, brain damage, or death. I further authorize Dr. Pamela R. Singletary to perform treatment as may be advisable to preserve the health and life of my child.

I hereby state that I have read and understand this consent and the behavior management techniques on page 4 (if applicable) and that all questions about the procedure or procedures have been answered in a satisfactory manner; I understand that I have a right to be provided with answers to questions which may arise during the course of my child's treatment. I further understand that this consent will remain in effect until such time that I chose to terminate it (Termination of agreement must be presented in writing.)

Date: ____________________ Time: ________________ am/pm

Patient Name(s):____

Signature of Parent of Guardian: ____

Relationship to Patient: _________________________ Witness Signature: _________________________

TEXAS TOOTH FAIRIES PEDIATRIC DENTISTRY
PAMELA R.SINGLETARY, DDS

Patient Name(s) ____

BEHAVIOR MANAGEMENT TECHNIQUES

It is our intent that all professional care delivered in our dental office be the best possible quality we can provide for each child. Providing a high quality of care can sometimes be made very difficult or even impossible, because of the lack of cooperation of some children. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity, resistive movements, refusing to open the mouth or keep it open long enough to perform the necessary dental treatment and even aggressive or physical resistance to treatment, such as kicking, screaming and grabbing the dentist's hands or the sharp dental instruments.
All efforts will be made to obtain the cooperation of the child by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness and understanding.
There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of children to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. The more frequently used pediatric dentistry behavior management techniques are as follows:

1. **Tell-show-do**: The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstration with instruments on a model or the child's or dentist's finger. Then the procedure is performed on the child's mouth as described. Praise is used to reinforce cooperative behavior.
2. **Positive reinforcement**. This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, a pat on the back, a hug or prize.
3. **Voice Control**: The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important that the abrupt or sudden nature of the command.
4. **Mouth Props**: A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth. The item is referred to as a "**pillow**" and simply aids the child in keeping his/her mouth open.
5. **Head Control:** The dentist stabilizes the child's head between the dentist's arm and body. The dental assistant may often assist in stabilizing the child's head and preventing the child from flaring their head while the dentist performs the restorative procedure which is deemed necessary.
6. **Physical Restraint by the Assistant:** The assistant restrains the child from movement by holding the child's hands, stabilizing the head and/or controlling leg movements. Dr. Singletary may ask you to assist in controlling your child.
7. **Papoose Boards & Pedi-Wraps:** These are restraining devices for limiting the disruptive child's movements to prevent injury and to enable the dentist to provide the necessary treatment. The child is wrapped in this device and placed in a reclined dental chair. We refer to these devices as a "**blanket**" or "**tiny surf-board**" so as not to frighten the child. This device will not be used without your being further informed and obtaining your specific approval and consent for such procedures.
8. **Sedation**: Sometimes drugs are used to relax a child who does not respond to other behavior management techniques or who is unable to comprehend or cooperate for the dental procedures. These drugs may be administered orally. The child does not become unconscious. Your child will not be sedated without you being further informed and obtaining your specific consent for such procedure.
9. **General anesthesia**: The dentist performs the dental treatment with the child anesthetized in the hospital operating room. Your child will not be given anesthesia without your being further informed and obtaining your specific consent for such procedure.

*I hereby state that I have read and understand this **Behavior Management Techniques Form**, that I have been given the opportunity to ask questions I might have and that **all questions** about the procedures **circled** have been answered in a satisfactory manner.*

BY SIGNING THIS SHEET I HERBY GIVE DR.SINGLETARY & HER ASSISTANTS CONSENT TO USE THESE BEHAVIOR MANAGEMENT TECHNIQUES ON MY CHILD.

____ ______________________________
SIGNATURE OF PARENT, GUARDIAN OR RESPONSIBLE PARTY **DATE**

____ ______________________________
PRINTED NAME **RELATIONSHIP TO PATIENT(S)**

TEXAS TOOTH FAIRIES PEDIATRIC DENTISTRY
PAMELA R.SINGLETARY, DDS

Patient Name(s) ____

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our front office staff or office manager. We are dedicated to providing the best possible care and service to your child and regard your complete understanding of our financial policies as an essential element of care and treatment.

1. **Payment is due at the time of service**. For your convenience, we will accept Cash, Check, Visa, Master Card, Discover, American Express and Care Credit.
2. **Your insurance is a contract between you and your insurance company**. As a courtesy, after your first initial visit and upon verification of coverage, we will file your insurance claim for you if you assign the benefits to the doctor; in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
3. **We are contracted with most major insurance carriers.** Please verify Dr. Singletary is listed on your plan if you are concerned about utilizing your "in network benefits" or ask our front office staff for further details.
4. **All dental plans are not the same and do not cover the same services**. In the event your dental plan determines a service to be "not covered" or over what they deem "usual and customary charges"' you will be responsible for this amount.
5. **Insurance companies will not "guarantee payment" for any services**, therefore any estimation given of coverage by your dental plan cannot be guaranteed by our office.
6. **Payment is due upon receipt of statement from our office.** If payment is not made upon receipt of our statement, we will no longer file your insurance. Therefore we will expect payment in full at the time of service. We do honor some Discount Dental plans so please ask our front office staff to see if we accept your plan.
7. **Your estimated portion of our fees for scheduled hospital procedures is due when scheduling the surgery date.** Any balance remaining after your dental plan pays is your responsibility and payment is due upon receipt of statement from our office.
8. **The adult accompanying** the child is responsible for payment for services rendered to a child patient.
9. **We are not a party to divorce decrees.** By signing this form you agree that you are the sole person responsible to us for your child's bill. You must coordinate and seek payment from any other party you feel shares this obligation.
10. **Missed Appointment(s) Policy – Although, we make every attempt to remind you of your scheduled appointment, it is your responsibility to remember all appointment date(s)/time(s). The doctor has reserved this time, especially for you and your child to meet their dental needs. Cancellations require a 24 hour prior notice, or your account may be assessed a $25 missed appointment fee.**

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

____ ________________________

SIGNATURE OF RESPONSIBLE PARTY **DATE**

____

PRINTED NAME

RELATIONSHIP TO PATIENT(S) ______________________________

TEXAS TOOTH FAIRIES PEDIATRIC DENTISTRY
PAMELA R.SINGLETARY, DDS

Patient Name(s) ____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION AND SUBMISION OF CLAIMS AND ASSIGNMENT OF BENEFITS

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Dr. Singletary to release to hospitals or health care service plans, insurance companies, self-insurers or their representatives, any and all information and records (including x-rays) about my medical history, services rendered or treatment given to my child/children that is needed to review, investigate or evaluate any claim for benefits. If my coverage is under a group master agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization, review or financial audit.

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

I authorize Dr. Singletary to submit claims for payment for services to healthcare service plans or insurance companies, on my behalf and in my name and assign to Dr. Singletary the groups insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for covered services. I authorize and request my insurance company to pay directly to the dentist or dental group, any insurance benefits otherwise payable to me.

This authorization shall remain in effect until written notice is given by either party. I know I have a right to receive a copy of this authorization if requested. I also understand that although Dr. Singletary strives to give the most accurate insurance information possible with regards to my plan, it is ultimately my responsibility as the parent/insured/subscriber to know and understand my benefits, limitations and exclusions of my individual policy.

I understand that I am responsible for handling any disputes regarding amount of payment with the insurance company. I agree to be responsible for payment of all services rendered on behalf of my dependent(s), including any balance not paid by the dental insurance company within 30 days of the date of service. I understand that payment of a calculated % is due at the time treatment is rendered and that my dental insurance carrier may pay less than the actual bill for service.

(NOTE: WE ARE FILING YOUR INSURANCE AS A COURTESY. FOR US TO CONTINUE THIS SERVICE, WE ASK THAT ANY BALANCE NOT PAID BY YOUR INSURANCE COMPANY BE PAID BY YOU AT THE TIME YOU RECEIVE OUR STATEMENT.)

____ ____________________

SIGNATURE OF RESPONSIBLE PARTY **DATE**

____

PRINTED NAME

RELATIONSHIP TO PATIENT(S) ____________________________

TEXAS TOOTH FAIRIES PEDIATRIC DENTISTRY

PAMELA R.SINGLETARY, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ________________________________, have received a copy of this office's Notice of Privacy Practices for the following patient(s) ____.

____

(Please Print Name)

____

(Signature)

____

(Date)

For Office Use Only

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

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

____

____

____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

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

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

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

USES AND DISCLOSURES OF HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

PATIENT'S 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 requested unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

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

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

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

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

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

QUESTIONS AND COMPLAINTS

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

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your access to your health information or in response to a request 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 the U.S. Department of Health and Human Services.

Company: Texas Tooth Fairies Pediatric Dentistry, Pamela R. Singletary, DDS
Contact Officer: Julie Brooks
Telephone: 512-401-8888
Address: 3401 El Salido Pkwy. Cedar Park,TX 78613
E-mail: julie@texastoothfairies.com

© 2002 American Dental Association
All Rights Reserved
Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002)