Welcome!

We are happy you chose us for your child's dental needs.
Please take a few minutes and fill out these forms completely.
Do not hesitate to ask us any questions.
We look forward to making dentistry fun for your child.

PATIENT INFORMATION

Last Name	First Name	Middle Name	☐M ☐F
Preferred Name	Birthdate	Age	Social Security #	Sex
Physical Address	City	State	Zip
Mailing Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	E-Mail Address

RESPONSIBLE PARTY INFORMATION

Last Name	First Name	Middle Name	☐M ☐F Sex
			Single / Mar / Div / Sep / Other
Relationship to Patient	Birthdate	Social Security #	Marital Status (circle one)
Physical Address (if different from above)	City	State	Zip
Mailing Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	E-Mail Address
Occupation	Employer	Employer Phone	Employer Address

Last Name	First Name	Middle Name	☐M ☐F Sex
			Single / Mar / Div / Sep / Other
Relationship to Patient	Birthdate	Social Security #	Marital Status (circle one)
Physical Address (if different from above)	City	State	Zip
Mailing Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	E-Mail Address
Occupation	Employer	Employer Phone	Employer Address

Ben Saunders, D.M.D. Pediatric Dentistry

Keeping Kids Smiling

4711 Highway 90 - Marianna, FL 32446
Phone: (850)526-SPIT - Fax: (850)526-3388
www.allhappyteeth.com

INSURANCE INFORMATION

Is this Patient Covered By Insurance? ☐YES ☐ NO IF yes, does this patient have dual coverage? ☐YES ☐ NO

Name of PRIMARY Insurance	Insurance Company Address		Insurance Company Phone #
Subscriber's Last Name	First Name	Subscriber's ID (SSN)	Subscriber's Birthdate
		☐ Child ☐ Self ☐ Other	
Group #	Policy #	Patient's Relationship to Subscriber (check box above)	

Name of SECONDARY Insurance	Insurance Company Address		Insurance Company Phone #
Subscriber's Last Name	First Name	Subscriber's ID (SSN)	Subscriber's Birthdate
		☐ Child ☐ Self ☐ Other	
Group #	Policy #	Patient's Relationship to Subscriber (check box above)	

PATIENT DENTAL HISTORY

Is this your child's first visit to a dental office? ☐YES ☐ NO Date of Last Dental Visit:_____
Previous Dentist: _____ For what service? _____
Previous Dentist City/State:_____ Previous Dentist Phone: _____
Have you been satisfied with your child's previous dental care? ☐YES ☐ NO
Has your child had any trouble associated with any previous dental treatment? ☐YES ☐ NO

Has child complained about dental problems?	☐YES ☐ NO	Is fluoride taken in any form?	☐YES ☐ NO
Does child brush daily?	☐YES ☐ NO	Any injuries to mouth, teeth, head?	☐YES ☐ NO
Does child use floss daily?	☐YES ☐ NO	Any unhappy dental experiences?	☐YES ☐ NO
Do gums bleed while brushing or flossing?	☐YES ☐ NO	Sensitivity to hot/cold/sweet/sour?	☐YES ☐ NO
Does child experience any pain in teeth?	☐YES ☐ NO	Has child had any previous orthodontic work?	☐YES ☐ NO

Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐YES ☐ NO

IN CASE OF EMERGENCY

Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone

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PATIENT HEALTH HISTORY

TODAY'S DATE:_____

Pediatrician_____City/State:_____Phone:_____

Date of last Physical Exam:_____ Results: _____

Is Child under care of Physician Now? ☐YES ☐ NO If yes, why?_____

Receiving any medications or drugs? ☐YES ☐ NO If yes, why?_____

List all medications child is currently taking:_____

_____

Ever been hospitalized? ☐YES ☐ NO If yes, why?_____

Ever had surgery? ☐YES ☐ NO If yes, why?_____

Has child ever had any asthmatic attacks? ☐YES ☐ NO If yes, ☐ Mild ☐ Moderate ☐ Severe Frequency:_____

Does child have any type of syndrome? ☐YES ☐ NO If yes, which?_____

_____

☐YES ☐ NO A.I.D.S./H.I.V	☐YES ☐ NO Cleft Lip/Palate	☐YES ☐ NO Hearing Problems	☐YES ☐ NO Mononucleosis
☐YES ☐ NO Anemia	☐YES ☐ NO Convulsions	☐YES ☐ NO Heart Problems	☐YES ☐ NO Mumps
☐YES ☐ NO Bladder Problems	☐YES ☐ NO Developmental Disabled	☐YES ☐ NO Hepatitis	☐YES ☐ NO Rheumatic Fever
☐YES ☐ NO Blood Transfusion	☐YES ☐ NO Diabetes	☐YES ☐ NO Jaundice	☐YES ☐ NO Sinus Problems
☐YES ☐ NO Bruise Easily	☐YES ☐ NO Drug/Alcohol Abuse	☐YES ☐ NO Kidney Disease	☐YES ☐ NO Thyroid Disease
☐YES ☐ NO Cancer	☐YES ☐ NO Epilepsy	☐YES ☐ NO Liver Disease	☐YES ☐ NO Tuberculosis
☐YES ☐ NO Cerebral Palsy	☐YES ☐ NO Fainting	☐YES ☐ NO Measles	☐YES ☐ NO Premature
☐YES ☐ NO Chicken Pox	☐YES ☐ NO Hay Fever	☐YES ☐ NO Mental Disability	Other:

Comments:_____

IS CHILD ALLERGIC TO; EVER HAD AN ADVERSE REACTION TO THE FOLLOWING?

☐YES ☐ NO Penicillin	☐YES ☐ NO Amoxicillin	☐YES ☐ NO Sulfa Drugs	☐YES ☐ NO Latex
☐YES ☐ NO Local Anesthetics	☐YES ☐ NO General Anesthesia	☐YES ☐ NO Sedatives	Other:_____
☐YES ☐ NO Vaccines	IF yes, which?_____		

AUTHORIZATION

The information I have given is correct to the best of my knowledge. I understand it is my responsibility to inform my doctor of any changes in my child/self. I certify that I am the parent, guardian, or person representative of _____ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. I certify that my dependent(s) is covered by insurance with _____ and assign directly to Ben Saunders, DMD Pediatric Dentistry, PL all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Print Name of Minor/Child

Name of Insurance Company(ies)

Ben Saunders, DMD Pediatric Dentistry, PL may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Parent, Guardian or Personal Representative Relationship to Patient

PATIENT HEALTH HISTORY
(to be completed at next appointment)

TODAY'S DATE:_____
Pediatrician_____City/State:_____Phone:_____
Date of last Physical Exam:_____ Results: _____
Is Child under care of Physician Now? ☐YES ☐ NO If yes, why?_____
ANY CHANGES TO MEDICAL HISTORY? ☐YES ☐ NO If yes, why?_____
ANY CHANGES IN MEDICATION? ☐YES ☐ NO If yes, why?_____
List all medications child is currently taking:_____
_____
Recently hospitalized? ☐YES ☐ NO If yes, why?_____
Any Recent Surgeries? ☐YES ☐ NO If yes, why?_____
Any asthmatic attacks? ☐YES ☐ NO If yes, ☐ Mild ☐ Moderate ☐ Severe Frequency:_____

Comments:_____
_____

PATIENT HEALTH HISTORY
(to be completed at next appointment)

TODAY'S DATE:_____
Pediatrician_____City/State:_____Phone:_____
Date of last Physical Exam:_____ Results: _____
Is Child under care of Physician Now? ☐YES ☐ NO If yes, why?_____
ANY CHANGES TO MEDICAL HISTORY? ☐YES ☐ NO If yes, why?_____
ANY CHANGES IN MEDICATION? ☐YES ☐ NO If yes, why?_____
List all medications child is currently taking:_____
_____
Recently hospitalized? ☐YES ☐ NO If yes, why?_____
Any Recent Surgeries? ☐YES ☐ NO If yes, why?_____
Any asthmatic attacks? ☐YES ☐ NO If yes, ☐ Mild ☐ Moderate ☐ Severe Frequency:_____

Comments:_____
_____

PATIENT HEALTH HISTORY
(to be completed at next appointment)

TODAY'S DATE:_____
Pediatrician_____City/State:_____Phone:_____
Date of last Physical Exam:_____ Results: _____
Is Child under care of Physician Now? ☐YES ☐ NO If yes, why?_____
ANY CHANGES TO MEDICAL HISTORY? ☐YES ☐ NO If yes, why?_____
ANY CHANGES IN MEDICATION? ☐YES ☐ NO If yes, why?_____
List all medications child is currently taking:_____
_____
Recently hospitalized? ☐YES ☐ NO If yes, why?_____
Any Recent Surgeries? ☐YES ☐ NO If yes, why?_____
Any asthmatic attacks? ☐YES ☐ NO If yes, ☐ Mild ☐ Moderate ☐ Severe Frequency:_____

Comments:_____
_____

Ben Saunders, D.M.D. ◆ Pediatric Dentistry

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist, Dr Ben Saunders, or his dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.

To the extent permitted by law, I give Dr. Ben Saunders consent to use and disclose my protected health information to carry out payment activities.

Date _____

Patient Name

_____

Signature of Parent or Legal Guardian

_____

Relationship to Patient

_____

4711 Highway 90 Marianna, FL 32446
Phone: (850) 526-SPIT Fax: (850) 526-3388

Ben Saunders, D.M.D. ◆ Pediatric Dentistry

Informed Consent

As pediatric dentists, we enjoy treating children, but there are a variety of concerns when dealing with their behavior. Some children may need assistance to cooperate. That is why we have received special training to help guide children through the dental experience and make it a pleasurable one. The purpose of this form is to explain the various methods we may use to manage young children, to get your consent for use of these methods with your child, and to familiarize you with some of our office policies. Please initial after each section certifying that you have read the explanation and have had any questions concerning the procedure answered to your satisfaction.

Tell-Show-Do:
Tell-show-do is a method used with children in which we explain what is to be expected at each visit. First, we tell them what is to be done. Then we show them how it is done. Finally, we do the procedure. _____

Nitrous Oxide Sedation:
Some anxious children are given nitrous oxide, or what you may know as laughing gas, to relax them for their dental treatment. The nitrous oxide is
given through a small breathing mask which is placed over the child's nose, allowing them to relax, but without putting them to sleep. As soon as the mask is removed, the effects of the gas wear off within five minutes. Children receiving N_2O are not to eat or drink anything for 4 hours before the dental procedure. _____

Voice Control:
Voice control is a method that we use with a child who is capable of understanding, but is not listening to what we are saying. After several unsuccessful attempts of trying to communicate with the child, we change the tone or volume of our voice to convey a firm attitude, but we do not get angry with the child. Once we have their cooperation and attention, we praise the child for helping. _____

Active Restraint by Dental Personnel:
Active restraint by dental personnel is when the dental assistant or dentist must hold an uncooperative child to keep them from making movements during a procedure. This is done so they will not hurt themselves. For example, the dental assistant may hold the child's hands, head, or legs while the dentist numbs the teeth. _____

Parents in Clinic Area
A one-on-one relationship is developed with every child and an efficient environment is maintained during every procedure. For this reason only the doctor and assistant are permitted in the clinic area. _____

Legal Guardian:
A parent or legal guardian must be present during all treatment planning sessions & conscious sedation appointments. If this is not possible, the parent must obtain a notarized letter granting a second party permission to make all dental treatment planning decisions, including behavior management and sedation when necessary. _____

I authorize Dr. Ben Saunders to use photographs, radiographs, and/or working models of _____ taken during the course of treatment for teaching purposes. I understand that his/her identity will remain undisclosed. _____

I authorize Dr. Ben Saunders and his assistants as selected by him, to utilize the aforementioned behavior management techniques as they deem necessary to treat _____ who is a minor. I understand the office policies as written and explained to me and agree to adhere to these policies while my child is undergoing dental treatment.

I have been made aware of the dental treatment prescribed for my son/daughter and am fully aware of the side effects and risk factors involving such treatment. I authorize Dr. Ben Saunders and his assistants as selected by him to complete the aforementioned treatment as they deem necessary to treat _____ who is a minor.

Signature of Legal Guardian: _____

Date: _____

Relationship to child: _____

Witness: _____

Ben Saunders, D.M.D. ◆ Pediatric Dentistry
4711 Highway 90 – Marianna, FL 32446

NOTICE OF PRIVACY PRACTICES

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

For purposes of this Notice "us" "we" and "our" refers to **Ben Saunders, DMD**, and "you" or "your" refers to **our patients (or their legal representatives as determined by us in accordance with Florida informed consent law)**. When you receive health-care services from us, we will obtain access to your medical information (e.g., your health history). We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so.

Florida law and Health Insurance Portability & Accountability Act of 1996 **(HIPAA)** requires us to maintain the confidentiality of all your health-care records and other individually identifiable health information used by or disclosed to us in any form, whether electronically, on paper, or orally, (**"PHI" or Protected Health Information**). HIPAA is a federal law that gives you significant new rights to understand and control how your health information is used. HIPAA and Florida law provide penalties for covered entities and records owners, respectively, that misuse or improperly disclose PHI.

Starting April 14, 2003, HIPAA requires us to provide you with this Notice of our legal duties and the privacy practices we are required to follow when you first come into our office for health-care services. If you have any questions about this Notice, please ask to speak with our privacy officer, Olivia Garney (850) 526-7748, 4711 Hwy. 90, Marianna, FL 32446.

Our doctors, clinical staff, Business Associates (outside contractors we hire), employees and other office personnel follow the policies and procedures set forth in this notice. If your regular doctor is unavailable to assist you (e.g., illness, on-call coverage, vacation, etc.), we may provide you with the name of another health-care provider outside our practice for you to consult with by telephone. If we do so, that provider will follow the policies and procedures set forth in this notice or those established for his or her practice, so long as they substantially conform to those for our practice.

OUR RULES ON HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Under the law (§456.074, Fla. Stats., and HIPAA), we must have your signature on a written, dated Consent form and/or an Authorization form (not an Acknowledgment form) before we will use and disclose your PHI for certain purposes as detailed in the rules below.

Documentation You will be asked to sign a Consent form and/or an Authorization form when you receive this Notice of Privacy Practices. If you do not sign such a form or if you need a copy of the one you signed, please contact our privacy officer. You may take back or revoke your Consent or Authorization at any time (unless we already have acted based on it) by submitting our Revocation form in writing to us at our address listed above. Your revocation will take effect when we actually receive it. We cannot give it retroactive effect, so it will not affect any use or disclosure that occurred in our reliance on your Consent or Authorization prior to revocation.

General Rule If you do not sign our **Consent** form or if you revoke it, as a general rule (subject to exceptions described below under "Healthcare Treatment, Payment and Operations Rule" and "Special Rules"), we cannot in any manner use or disclose to anyone (excluding you, but including payers and Business Associates) your PHI or any other information in your medical record. Under Florida law, we are unable to submit claims to payers under assignment of benefits without your signature on our Consent form. We will not condition treatment on your signing and Authorization, but we may be forced to decline you as a new patient or discontinue you as an active if you choose not to sign the Consent or revoke it.

PLEASE READ THE FOLLOWING 3 PAGES BEFORE SIGNING

Signature: _____ Date:_____

Relationship to child: _____

Health-care Treatment, Payment and Operations Rule With your signed Consent, we may use or disclose your PHI in order:

- To provide you with or coordinate health-care treatment and services.
- To bill or collect payment from you, and insurance company, a managed-care organization, a health benefits plan or another third party.
- To run our office, assess the quality of care our patients receive and provide you with customer service.

Special Rules Not withstanding anything else contained in this Notice, only in accordance with applicable law, and under strictly limited circumstances, we may use or disclose your PHI without your permission, Consent or Authorization for the following purposes.

- When required under federal, state or local law
- When necessary in emergencies to prevent a serious threat to your health and safety or the health and safety or other persons
- When necessary for public health reasons
- For federal or state government health-care oversight activities
- For judicial and administrative proceedings and law enforcement purposes
- For workers' compensation purposes
- For intelligence, counterintelligence or other national security purposes
- For organ and tissue donation
- For research projects approved by and Institutional Review Board or a privacy board to ensure confidentiality (e.g., if the researcher will have access to your PHI because involved in your clinical care, we will ask you to sign an Authorization)
- To create a collection of information that is "de-identified"
- To family members, friends and others, but only if you verbally give permission; we give you an opportunity to object and you do not; we reasonably assume, based on our professional judgment and the surrounding circumstances, that you do not object (e.g., you bring someone with you into the operatory or exam room during treatment or into the conference area when we are discussing your PHI); we reasonably infer that it is in your best interest (e.g., to allow someone to pick up your records because they knew you were our patient and you asked them in writing with your signature to do so); or it is an emergency situation involving you or another person (e.g., your minor child or ward) and, respectively, you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because, after a reasonable attempt, we have been unable to locate you. In these emergency situations we may, based our professional judgment and the surrounding circumstances, determine that disclosure is in the best interests of you or the other person, in which case we will disclose PHI, but only as it pertains to the care being provided and we will notify you of the disclosure as soon as possible after the care is completed.

Minimum Necessary Rule Our staff will not use or access your PHI unless it is necessary to do their jobs. Also, we disclose to others outside our staff only as much of your PHI as is necessary to accomplish the recipient's lawful purposes. For example, we may use and disclose the entire contents of your medical record:

- To you (and your legal representatives as stated above) and any one else you list on a Consent or Authorization to receive a copy of your records
- To health-care providers for treatment purposes
- To the U.S. Department of Health and Human Services
- To others as required under federal or Florida law
- To our privacy officer and others as necessary to resolve your complaint or accomplish your request under HIPAA

In accordance with the law, we presume that requests for disclosure of PHI from another Covered Entity (as defined in HIPAA) are for the minimum necessary amount of PHI to accomplish the requester's purpose. Our privacy officer will individually review unusual or non-recurring requests for PHI to determine the minimum necessary amount of PHI and disclose only that. For non-routine requests or disclosures, the Plan's Privacy Officer will make a minimum necessary determination based on, but not limited to, the following factors:

- The amount of information being disclosed
- The number of individuals or entities to whom the information is being disclosed
- The importance of the use or disclosure
- The likelihood of further disclosure
- Whether the same result could be achieved with de-identified information
- The technology available to protect confidentiality of the information
- The cost to implement administrative, technical and security procedures to protect confidentiality

If we believe that a request from others for disclosure of your entire medical record is unnecessary, we will ask the requester to document why this is needed, retain that documentation and make it available to you upon request.

Incidental Disclosure Rule We will take reasonable administrative, technical and security safeguards to ensure the privacy of your PHI when we use or disclose.

Business Associate Rule Business Associates and other third parties (if any) that receive your PHI from us will be prohibited from re-disclosing it unless required to do so by law or you give prior express written consent to the re-disclosure. Nothing in our Business Associate agreement will allow our Business Associate to violate this re-disclosure prohibition.

Super-confidential Information Rule If we have PHI about you regarding HIV testing, alcohol or substance abuse diagnosis and treatment, or psychotherapy and mental health records (super-confidential information under the law), we will not disclose it under the General or Health-care Treatment, Payment and Operations Rules (see above) without you first signing and properly completing our Consent form (i.e., you specifically must initial the type of super-confidential information we are allowed to disclose). If you do not specifically authorize disclosure by initialing the super-confidential information, we will not disclose it unless authorized under the Special Rules (see above). If we disclose super-confidential information (either because you have initialed the Consent from or the Special Rules authorize us to do so), we will comply with state and federal law that requires us to warn the recipient in writing that re-disclosure is prohibited.

Changes to Privacy Policies Rule We reserve the right to change our privacy practices (by changing the terms of this Notice) at any time as authorized by law. The changes will be effective immediately upon us making them. They will apply to all PHI we create or receive in the future, as well as to all PHI created or received by us in the past. If we make changes, we will post the changed Notice, along with its effective date, in our office. Also, upon request, you will be given a copy of our current Notice.

Authorization Rule We will not use or disclose your PHI for any purpose or to any person other than as stated in the rules above without your signature on a specifically worded, written Authorization form (not a Consent or an Acknowledgement). If we need your Authorization, we must obtain it on our Authorization form, which is separate from any Consent or Acknowledgement we may have obtained from you. We will not condition treatment on whether you sign the Authorization (or not).

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

If you got this Notice via e-mail or web-site, you have the right to get, at any time, a paper copy by asking our privacy officer. Also, you have the following additional rights regarding PHI we maintain about you:

To Inspect and Copy You have the right to see and get a copy of your PHI including, but not limited to, medical and billing records by submitting a written request to our privacy officer on our Request to Inspect, Copy or Summarize form. Original records will not leave the premises, will be available for inspection only during our regular business hours, and only if our privacy officer is present at all times. You may ask us to give you the copies in a format other than photocopies (and we will do so unless we determine that it is impracticable) or ask us to prepare a summary in lieu of copies. We may charge you a fee not to exceed Florida law to recover our costs (including postage, supplies and staff time as applicable, but excluding staff time to search and retrieval) to duplicate or summarize PHI. We will not condition release of the copies or summary on payment of your outstanding balance for professional services (if you have one), but we may condition release of the copies or summary on payment of your outstanding balance for professional services (if you have one), but we may condition release of the copies or summary on payment of the copying fees. We will respond to requests in a timely manner, without delay for legal review, in less than thirty days if submitted in writing on our form or otherwise, and in ten business days or less if malpractice litigation or pre-suit production is involved. We may deny your request, you may ask for a review of that decision. If required by law, we will select a licensed health-care professional (other than the person who denied your request initially) to review the denial and we will follow his or her decision. If we select a licensed health-care professional who is not affiliated with us, we will ensure a Business Associate agreement is executed that prevents re-disclosure of your PHI without your consent by the outside professional.

To Request Amendment/Correction If another doctor involved in your care tells us in writing to change your PHI, we will do so as expeditiously as possible upon receipt of the changes and will send you written confirmation that we have made the changes. If you think PHI we have about you is incorrect, or that something important is missing fro your records, you may ask us to amend or correct it (so long as we have it) by submitting a Request for Amendment/Correction form to our privacy officer. We normally will act on your request within 60 days from receipt, but we may extend our response time (within 60day period) no more than once and by no more than 30 days, in which case we will notify you in writing why and when we will be able to respond. If we grant your request, we will let you know within 5 business days, make the changes by noting (not deleting) what is incorrect or incomplete and adding to it the changed language, and send the changes within 5 business days to persons you ask us to and persons we know may rely on incorrect or incomplete PHI to your detriment (or already have). We may deny your request under certain circumstances (e.g., it is not in writing, it does not give a reason why you want the change, we did not create the PHI you wanted changed (and the entity that did can be contacted), it was compiled for use in litigation, or we determine it is accurate and complete). If we deny your request, we will

(in writing within 5 business days) tell you: why and how to file a complaint with us if you disagree, that you may submit a written disagreement with our denial (and we may submit a written rebuttal and give you a copy of it), that you may ask us to disclose your initial request and our denial when we make future disclosures of PHI pertaining to your request, and that you may complain to us and the U.S. Department of Health and Human Services.

To an Accounting of Disclosures You may ask us for a list of those who got your PHI from us by submitting a Request for Accounting of Disclosures form to us. The list will not cover some disclosures (e.g., PHI given to you, given to your legal representative, given to others for treatment, payment or health-care-operations purposes). Your request must state in what form you want the list (e.g., paper or electronically) and the time period you want us to cover, which may be up to but no more than the last six years (excluding dates before April 14, 2003). If you ask us for this list more than once in a 12-month period, we may charge you reasonable, cost-based fee to respond, in which case we will tell you the cost before we incur it and let you choose if you want to withdraw or modify your request to avoid the cost.

To Request Restrictions You may ask us to limit how your PHI is used and disclosed by submitting a written Request for Restrictions on Use/Disclosure form to us. If we agree to these additional limitations, we will follow them except in an emergency where we will not have time to check for limitations. Also, in some circumstances we may be unable to grant your request (e.g., we are required by law to use or disclose your PHI in a manner that you want restricted; you signed an Authorization form, which you may revoke, that allows us to use or disclose your PHI in the manner you want restricted; in an emergency).

To Request Alternative Communications You may ask us to communicate with you in a different way or at a different place by submitting a written Request for Alternative Communication form to us. We will not ask you why and we will accommodate all reasonable requests. You must tell us the alternative means or location you want us to use and explain to our satisfaction how payments to us will be made if we communicate with you as you request.

To Complain or Get More Information We will follow our rules set forth in this Notice. If you want more information or if you believe your privacy rights have been violated, we want to make it right. We never will penalize you for filing a complaint. To do so, please file a formal, written complaint with 180 days with:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
(877)696-6775 (toll-free)

Or, submit a written Complaint form to us at the following address:

Olivia Garney, Privacy Officer
4711 Highway 90
Marianna, FL 32446
(850) 526-7748

You may get your complaint form by calling our privacy officer.

These privacy practices will be effective April 14, 2003, and will remain in effect until we replace them as specified above.