



Phone: (914) 941-2200

**Chilmark Dental P.C.**

**15 Pleasantville Rd.**

**Ossining, NY 10562**

We are pleased you have selected us to provide dental care for you and your family

*Welcome*

## Patient Information (CONFIDENTIAL)

Email \_\_\_\_\_ Patient # \_\_\_\_\_

Cell # \_\_\_\_\_ Soc. Sec # \_\_\_\_\_

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

If Patient is a Student, Name of School / College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Person to Contact in Case of Emergency 1) \_\_\_\_\_ Phone \_\_\_\_\_

2) \_\_\_\_\_ Phone \_\_\_\_\_

3) \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Name of Person Responsible for this Account \_\_\_\_\_ to Patient \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Insurance ID # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How Much Is Your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max Annual Benefit \_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Insurance ID # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How Much Is Your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max Annual Benefit \_\_\_\_\_

**PLEASE COMPLETE OTHER SIDE OF FORM**

Chilmark Dental Welcome Patient Information and Health History

# Patient Medical History

Chilmark Dental,  
PC 15 Pleasantville  
Road Ossining, NY  
10562

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

- |                                                                                                                                   | Yes                      | No                       |
|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Are you under medical treatment now?.....                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness?.....                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine?.....<br>If yes, what medication(s) are you taking? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you use tobacco?.....                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use alcohol, cocaine or other drugs?.....                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you wearing contact lenses?.....                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |

Date of last TB test \_\_\_\_\_

9. Do you have or have you had any of the following?

|                              | Yes                      | No                       |
|------------------------------|--------------------------|--------------------------|
| High Blood Pressure .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack .....           | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles .....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting / Seizures .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy / Convulsions ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent Cough .....       | <input type="checkbox"/> | <input type="checkbox"/> |

|                                    | Yes                      | No                       |
|------------------------------------|--------------------------|--------------------------|
| Heart Disease .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac Pacemaker.....             | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequently Tired .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Replacement or Implant ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis / Jaundice .....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually Transmitted Disease ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach Troubles / Ulcers.....     | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse .....        | <input type="checkbox"/> | <input type="checkbox"/> |

- |                                                                             | Yes                      | No                       |
|-----------------------------------------------------------------------------|--------------------------|--------------------------|
| 7. Are you allergic to or have you had any reactions to the following?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Local Anesthetics (eg. novocaine) .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other Antibiotics .....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs .....                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates .....                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives .....                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine .....                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin .....                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Other .....                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Women Only:                                                              |                          |                          |
| a) Are you pregnant or think you may be pregnant?.....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Are you nursing?.....                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Are you taking birth control pills?.....                                 | <input type="checkbox"/> | <input type="checkbox"/> |

|                             | Yes                      | No                       |
|-----------------------------|--------------------------|--------------------------|
| Chest Pains .....           | <input type="checkbox"/> | <input type="checkbox"/> |
| Easily Winded .....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Hay Fever / Allergies ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis .....          | <input type="checkbox"/> | <input type="checkbox"/> |
| Radiation Therapy .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma .....              | <input type="checkbox"/> | <input type="checkbox"/> |
| Recent Weight Loss .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver Disease .....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Trouble .....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory Problems .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Other .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Cough with Blood .....      | <input type="checkbox"/> | <input type="checkbox"/> |
| Herpes .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Disorders .....       | <input type="checkbox"/> | <input type="checkbox"/> |

## Patient Dental History

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

- |                                                                                      | Yes                      | No                       |
|--------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 8. Do you have frequent headaches? .....                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you clench or grind your teeth? .....                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you bite your lips or cheeks frequently? .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had any difficult extractions in the past? .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you had any orthodontic work? .....                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever had any prolonged bleeding following extractions? .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had instruction on the correct method of brushing your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever had instructions on the care of your gums? .....                   | <input type="checkbox"/> | <input type="checkbox"/> |

## Authorization and Release

**There is a \$ 45.00 Fee for any missed appointments**

I 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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Date  
e

Signature of patient or parent if minor

Doctor's Comments

Signature

Date



## CHILMARK DENTAL P.C.

### **Payment & Financial Agreement**

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We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. In order to achieve these goals, we need your assistance and understanding of our payment and financial policy. We offer the following methods of payment:

- **Payment in full** is due at the time of service. Cash, Check, Debit Card, MasterCard, and Visa are accepted.
- For patients with insurance, we will accept payment directly from the insurance company, if it is assignable. We require that the deductible and non-covered fees be paid at each visit. We will do our best to calculate these fees prior to you leaving our office. Until we receive the explanation of benefits from your insurance company, we do not know the actual fees and additional fees may be due. You will receive a statement from our office stating the amount outstanding.
- We collaborate with Lending Tree for a financing option. Applications may be completed online at [www.lendingtree.com](http://www.lendingtree.com). If approved, print off approval with our account number and bring to your appointment.
- Any parent/guardian bringing a child to our office is legally responsible for payment of all services rendered. We do not bill individual parents for the child's co-payment.
- We offer an In-House Dental Discount Plan to patients without insurance. If you are interested in more information, please contact the front desk.
- For your convenience, we provide patients with the option to authorize the use of their credit card. These authorizations allow Chilmark Dental P.C. to charge a patient's credit card for unpaid copays or account balances in our office without your presence but only after your consent.

#### Important Information Regarding Your Dental Benefits

- Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy to you.
- Not all dental services are a covered benefit in all contracts. It is your responsibility to know your benefits.
- **You** (not the insurance company) are responsible to us for all our fees for services rendered to you.
- An **ESTIMATE** will be given of the benefits that the insurance company is expected to pay. Remember that this is only an **ESTIMATE** and that the actual cost may vary.
- **BROKEN/MISSED APPOINTMENT:** Appointments reserve a specific time with the dentist or hygienist to perform and provide the care you need. These scheduled times are planned for your convenience and hold great value. We require 24-hour notice of canceling or rescheduling your appointment, if 24 hours' notice is not given a \$45.00 fee will be charged.

**I acknowledge I have received and agreed to Chilmark Dental P.C.'s Payment & Financial Policies. Patient or Responsible Party:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Credit Card Authorization

I authorize Etta J. Lobel, D.M.D. of Chilmark Dental P.C. to charge my credit card as follows:

Select your preferred type of authorization:

- ☐ **Continuous Authorization:** Chilmark Dental P.C. will keep this information securely on file to cover any unpaid account balances, (Patients will be notified prior to credit card being charged).
- ☐ **One Time Authorization:** Chilmark Dental P.C. will use this information **ONCE** to cover any unpaid balances after payment from insurance for treatment dated \_\_\_\_\_ through \_\_\_\_\_
- ☐ **Broken/Missed Appointment:** Chilmark Dental P.C. will use this information in the event of broken, missed, or rescheduled appointments without adequate notice to cover the \$45.00 fee. Patients will be notified prior to credit card being charged.
- ☐ **Mutually Agreed Upon Payment Plan:** If patients require financial arrangements in the form of a payment plan to cover the cost of treatment, Chilmark Dental P.C. will arrange automatic monthly credit card charges per your request. (Agreed upon amounts may vary based on the cost of treatment. Payment plans shall not apply to Preventive and/or Basic procedures)

Please charge \$ \_\_\_\_\_ on or after the \_\_\_\_\_ of each month for:

☐ 01 Month      ☐ 02 Months      ☐ 03 Months

**(Final charge may also cover any unpaid balance on the account, which may be a greater amount than the amount listed above.)**

☐ **Decline:** I do not wish Chilmark Dental P.C. to keep my Credit Card on file.

Credit Card Information:

Credit Card:      ☐ Visa      ☐ MasterCard

Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_/\_\_\_\_ CVV Code: \_\_\_\_\_

Cardholder Signature \_\_\_\_\_ Printed Name \_\_\_\_\_

Billing Street Address/Zip Code: \_\_\_\_\_

\_\_\_\_\_

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program. We appreciate the opportunity to serve you and thank you for being an important part of our Chilmark Dental P.C. Family.

**Patient or Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Phone: (914) 941-2200

**Chilmark Dental P.C.**

**15 Pleasantville Rd.  
Ossining, NY 10562**

## Authorization for Signature on File

### Release of Information/Financial Responsibility/Authorization for Payment

I, \_\_\_\_\_ and/or \_\_\_\_\_  
Name of Patient (Parent or Guardian if Minor) Name of Insured

hereby authorize the office of Chilmark Dental P.C. to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with \_\_\_\_\_. I

hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and material not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim

This "Authorization" will be valid from this date forward and shall expire if my employment with the above company terminates.

A photocopy of this document may act as an original.

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Witnessed by

\_\_\_\_\_  
Signature of Patient (Parent or Guardian if Minor)

Today's Date \_\_\_\_\_

Chilmark Dental Authorization for Signature on File

## Chilmark Dental, P.C.

15 PLEASANTVILLE ROAD  
OSSINING, NY 10562



\_\_\_\_\_  
(914) 941 -2200

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print) \_\_\_\_\_ have received  
a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



CHILMARK DENTAL, P.C.

15 PLEASANTVILLE  
ROAD OSSINING, NY 10562

# 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

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect April 14, 2003, 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 applicable law permits the changes. 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 health care operations. For example:

**Treatment:** We may use your health information for treatment or disclose it to a dentist, 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. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

**Health Care Operations:** We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

**On Your Authorization:** 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 uses 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 may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

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

**Disaster Relief:** We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

**Public Benefit:** We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;

- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

## 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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. 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 may—but are not required to—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 more information about fees.

**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 (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

**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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

**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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. 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.

**Dr. Etta J. Lobel - Chilmark Dental P.C.**

Provider Contact Office: \_\_\_\_\_

Telephone: (914) 941-2200 Fax: (914) 941-5174

E-Mail: elseale2@aol

Address: 15 Pleasantville Road Ossining, NY 10562