Patient Registration

PATIENT INFORMATION (PLEASE PRESS DOWN FIRMLY WHEN PRINTING CLEARLY): Date: _____, 20 _____

Name _____
Last First Middle Initial

Street Address _____ DOB _____ Age _____ _____

City / State / Zip Code _____ M / F Occupation _____

Cell # (____) _____ Work # (____) _____ Home # (____) _____

Email _____ SSN # (last 4 digits)_____

Which would you prefer for notices: (circle one): email / US mail

Employer Name _____ Title _____ Work # (____) _____

Work Address _____
Street Address Apt / Space # City State Zip Code

Emergency Contact Person:_____ Phone Number: _____

Spouse / parent / guardian name _____ Relationship _____

Cell Phone: _____ Other Phone: (____) _____

(if spouse - a phone number other than home) The phone number(s) listed can be used to contact you for other than dental purposes

INCOMPLETE INSURANCE INFORMATION MAY RESULT IN CLAIM DENIAL BY THE PAYER!

PRIMARY DENTAL INSURANCE COMPANY:

Person Responsible for Payment: _____

SECONDARY DENTAL INSURANCE COMPANY:

Person Responsible for Payment: _____

Person Responsible for Payment: Please remember that insurance is considered a method of reimbursing fees paid and is not a substitute for payment. Some insurance companies pay a fixed dollar amount while others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your dental insurance carrier.

Note: A copy of your insurance plan information will be kept in your dental health record.

Who is your Primary Care doctor? _____

Address/Phone number for Primary Care doctor _____

Primary Language: _____

CONSENT AND ASSIGNMENT:

_____Initial - Consent to Treat: I hereby request and authorize Western University of Health Sciences to provide and perform such dental/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial for my health and well-being. It is understood that this consent is given in advance of any specific service, but is given in order that Western University of Health Sciences may exercise their best judgment as to proper medical care, which may be necessary to protect my life and health.

_____Initial - Assignment of Benefits: I hereby assign directly to the Western University of Health Sciences all dental 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 my insurance carrier.

Signature: _____ DATE: _____

(IF THE PATIENT IS A MINOR, SIGNATURE OF PARENT OR GUARDIAN AUTHORIZING TREATMENTS)

PLEASE COMPLETE, SIGN AND RETURN THIS FORM TO OUR STAFF

NOTE: Please notify us if any of the above information changes during the course of your treatment.

Est. 5-10, Rev.: 4-14; 5-17; 6-17

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INSTRUCTIONS ON HOW TO CONTACT PATIENT

Patient Name: _____ **Date of Birth:** _____

One of our goals is to protect your rights to privacy; therefore, unless we have your permission, information will not be given to anyone regarding you or your finances.

	Yes	No
May we call you at work?		
May we call you at home?		
If no to both questions above, do you have an alternative number, e.g., cell phone we can contact you at? If yes, what is that number?		
May we leave messages (including appointment information) on your answering machine/voice mail?		
May we send you a fax? If so, what is the phone number?		
May we send you an email? If so, what email address should we use?		

We will only provide information about you to those listed below:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

_____ _____

Patient/Guarantor Signature Date

Note: This consent is valid until otherwise notified in writing.

Note: A photocopy or electronic scan of this document shall be as valid as an original

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Patient Financial Responsibility Information

Payment Policy

The Western University of Health Sciences College of Dental Medicine Clinics are fee for service dental clinics. Payment for services using cash, Visa, MasterCard or Discover Card may be made using one of the following methods:

1. **Payment as treatment is rendered**- services are paid in full as they are completed.
2. **Pre-payment of fees –** regular payments are made prior to the start of an approved treatment plan procedure or phase. Appointments are scheduled when the total cost of the treatment or phase is paid.
3. **Phased treatment**- Certain treatment plans can be completed in phases allowing for intervals of time between each phase of dental care.
4. ***Care Credit*** – This form of payment is offered for approved treatment plans when the patient's financial obligation is more than $500.00. A no interest payment plan(s) (6 or 12 months) or low interest (24, 36 or 48 months) payment plans with credit approval from ***Care Credit.***
5. The Dental Center charges $20.00 for returned checks and reserves the right to request an alternate form of payment including the use of a collection agency to recover any amounts that are due and payable.

Assignment of Benefits and PHI Disclosure:

1. **ASSIGNMENT OF BENEFITS**: I hereby assign directly to The Dental Center at Western University all dental and or dental surgical 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.
2. **DISCLOSURE OF PHI:** I hereby authorize Western University College of Dental Medicine Clinics to receive and/or disclose protected health information (PHI) about me for the purpose of treatment, payment, and operations. I may revoke this authorization at any time. I understand that other disclosures will be made only with my written authorization, unless otherwise permitted or required by law. A completed "Notice of Privacy Practices" for Western University of Health Sciences, College of Dental Medicine Clinic will be provided to me.

Dental Insurance and Other Third Party Coverage:

The Western University Dental Center only accepts Delta Dental PPO, MetLife PPO and traditional Denti-Cal.

1. Patients covered with Delta Dental or MetLife insurance will be expected to pay their co-payment at each visit.
2. We *do not* participate in any HMO programs.
3. Patients with Denti-Cal will be expected to present their Beneficiary Identification Card (BIC) so that eligibility can be verified.
4. If we are not able to verify eligibility, payment for services must be made using one of the above methods.
5. Any procedures not covered by Delta Dental, MetLife or Denti-Cal are the patient's responsibility to pay.

Discontinuation of Services

If dental care is discontinued and:

1. A credit balance is exists, then a refund will be sent to the appropriate person, minus any cost of treatment received.
2. A balance for care exists, then the amount due is expected on the date the dental treatment is discontinued.

Person Responsible for Payment Declaration and Signature

As the person responsible for payment, I declare that I have read and understand that the financial obligations for me and/or those patients treated under my account and that the dental services must be paid within the policies and guidelines of the Western University Dental Center. ***I understand that the Western University of Health Sciences, College of Dental Medicine will provide good faith estimates of the cost of care and potential benefits and, estimates are not guarantees of the final costs of dental care or the actual third party payment.*** As the person responsible for payment I am responsible for all costs incurred by me/and or patients who are covered under my account.

_____ _____

Print Name Date

_____

Signature

A signed electronic copy of this form is as valid as the Original.

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AUTHORIZATION FOR PHOTOGRAPHY OF PATIENT

The undersigned patient, legal guardian or conservator, agrees that Western University of Health Sciences, College of Dental Medicine (CDM)may photograph me/the patient for the purposes of documenting my progress related to my health. My signature below indicates that I understand that:

- Photographs may be recorded to document my current care and treatment, and/or to document the progress of said treatment.
- The same statutory rules of patient privacy rights to confidentiality apply to any photographs taken by the Center.
- The Center will retain the ownership rights to these photographs, but that I will be allowed access to view them or obtain photocopies.
- These images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law.
- The images can be used without personal identifiers for teaching, academic / scientific presentations, professional portfolios and purposes not related to advertising or other commercial interests e.g., examples of surgical procedures or dental care provided by the student dentist for job interviews.
- The parts of my body that may be photographed are:

_____

_____ _____

Date Print Name

_____

Signature of Patient/Legal Representative/Conservator Signature

_____

Relationship

_____ _____

Date Witness Signature

_____

Witness's Printed Name

Note: A photocopy or electronic scan of this document shall be as valid as an original

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NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

DATE: _____, 20 _____

By signing this form, I acknowledge that I received a copy of Western University of Health Sciences' (WesternU) Notice of Privacy Practices. I understand that the Notice of Privacy Practices provides information about how WesternU may use and disclose my health information.

_____ _____

Patient Name (Print) Patient Signature

If this form is completed by a patient's legal representative, please print and sign your name in the space below:

_____ _____

Legal Representative (Print) Legal Representative's Signature

_____

Relationship

This Section to be Completed by WesternU:

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of WesternU's Notice of Privacy Practices but was unable to for the following reason:

□ Patient refused to sign
□ Patient unable to sign
□ Other _____

_____ _____ _____

Employee Name (Print) Employee Signature Date

This form must be placed in the patient's medical record.

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GENERAL INFORMED CONSENT

General Information: Western University of Health Sciences, College of Dental Medicine clinical sites will be referred to as the "WesternU CDM clinic(s)" in this document. I have elected to seek comprehensive dental care from WesternU CDM clinic(s). *I understand that it is possible that the WesternU CDM clinic(s) may not be able to meet my treatment needs and I* ***may not be accepted*** *for care at WesternU CDM clinic(s).* If I am not accepted, I will be provided with a list of low-cost dental clinics in the area. I also understand that dental care is provided by a team of dental students, licensed dental faculty and highly trained staff. I further acknowledge that a copy of the *"Dental Materials Fact Sheet"* has been offered to me and/or my dependents. I understand that I may ask questions regarding materials that may be used in dental procedures such as amalgam, composite resin, porcelain-fused to-metal, and gold alloy and their acceptability according to the American Dental Association guidelines. In addition, I acknowledge that I have also received a copy of the *"Patient Bill of Rights"* and the *"Privacy Notice."*

Treatment Plan: I understand that the *treatment plan* that I accepted is an **ESTIMATE** of the total cost of recommended dental treatment and that this *treatment plan* could change and/or the cost of care could increase during my treatment due to increase in fees, material or labor. In addition I acknowledge that it is possible, that as treatment progresses, my treatment plan may change and the cost of my treatment may also change in accordance with the new treatment plan. I also understand that I am encouraged to ask my student doctor questions about the procedures recommended on the treatment plan and that I should ask these questions before I give consent to the procedure. All dental procedures may involve risks or unsuccessful results or complications and no guarantees are made to any results or treatment outcomes. As the patient, or parent or guardian, I have the right to consent or refuse any proposed procedures at any time prior to its performance. WesternU CDM clinic(s) also reserves the right to not perform specific treatment requested by a patient. I further understand that payment is expected at the time of treatment and that I am responsible for the total cost of treatment. I understand that my insurance is a contract between myself, the insurance policy holder, and the insurance company; therefore, I am responsible for all care not covered by my insurance.

After Hours Emergency Care: WesternU CDM clinic(s) clinical sites hours may vary however most sites are open Monday-Friday, 9:00am-4:30pm. If an emergency or post-operative complication arises after these hours or on a weekend or holiday, ***I should call the main clinic telephone number at the clinical site and my call will be transferred to the answering service that will assist me in reaching my student dentist or an on-call faculty dentist.*** If I am experiencing bleeding that will not stop or swelling that is impairing my breathing in any way, or any life threatening emergency, I will go directly to my local emergency room for assistance.

Health: If I have any changes in my health status, changes in my medications or any recent hospitalizations, I will inform my student dentist. If I am taking a type of drug called bisphosphonates (i.e. Fosamax®, Actonel®, Boniva®, Skelid®, Didronel®, Aredia®, Zometa®, and Bonefos®), I will inform my student dentists as I may be at risk of developing osteonecrosis (bone death) of the jaw and certain dental treatments may increase that risk.

Keeping Appointments: I understand that it is my responsibility to keep appointments, and provide **at least 48 hours'** notice if I have to cancel an appointment. I also understand that if I continue to cancel or cancel appointments without sufficient notice, I will not be able to continue treatment at WesternU CDM clinic(s).

Discontinuance of Treatment: WesternU CDM clinic(s) reserves the right to discontinue my treatment. Should my treatment be terminated, any remaining credit balance for services not provided will be returned to me.

Dental Records: I understand that the dental record, X-rays, photographs, models and any other diagnostic aids that relate to my treatment here, are the property of WesternU CDM clinic(s). I acknowledge that I have the right to inspect these records and/or receive a copy of them or to request that they be sent to another health care provider. In order to obtain a copy of my records I will need to complete and sign a *Release of Information* form. WesternU CDM clinic(s) may charge a reasonable administrative fee for this service. WesternU CDM clinic(s) is authorized to furnish information from my dental records to my insurance company to obtain financial reimbursement for treatment provided to me.

Grievances: If I have concerns that my student dentist or dental faculty member cannot resolve, I understand that I can contact the WesternU CDM clinic(s) clinical to speak to my assigned Patient Care Coordinator or the site administrator.

Security: I understand that for security purposes cameras may be present throughout each of WesternU CDM clinic(s) clinical sites.

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Consent: I consent to examination, X-ray, models, photographs, diagnostic testing for the development of my proposed *treatment plan* and I further consent to any treatment procedures, which are diagnosed and indicated on the treatment plan. I agree that all records are the property of Western University of Health Sciences, College of Dental Medicine and may be used for teaching purposes or in scientific publications and that I am not entitled to any financial compensation.

Release: I understand my dental health care is not under warranty, expressed or implied. In addition, I agree to release, hold harmless and waive all claims, losses or damages resulting or relating to the treatment rendered hereunder by the student dentist, dental faculty or WesternU CDM clinic(s).

My signature below indicates that I have read and understand the above information and am willing to comply with the foregoing, and that I am the patient, the parent or guardian of the patient with authority to give consent, or that I am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient Name _____ **Date**_____

Signature of Patient/Parent or Guardian _____

Name of Parent/Guardian if applicable _____

Signature of Witness (Faculty or Student) _____

A signed electronic copy of this form is as valid as the Original.

Dental Materials – Advantages & Disadvantages

PORCELAIN FUSED TO METAL

This type of porcelain is a glass-like material that is "enameled" on top of metal shells. It is tooth-colored and is used for crowns and fixed bridges

Advantages

- Good resistance to further decay if the restoration fits well
- Very durable, due to metal substructure
- The material does not cause tooth sensitivity
- Resists leakage because it can be shaped for a very accurate fit

Disadvantages

- More tooth must be removed (than for porcelain) for the metal substructure
- Higher cost because it requires at least two office visits and laboratory services

GOLD ALLOY

Gold alloy is a gold-colored mixture of gold, copper, and other metals and is used mainly for crowns and fixed bridges and some partial denture frameworks

Advantages

- Good resistance to further decay if the restoration fits well
- Excellent durability; does not fracture under stress
- Does not corrode in the mouth
- Minimal amount of tooth needs to be removed
- Wears well; does not cause excessive wear to opposing teeth
- Resists leakage because it can be shaped for a very accurate fit

Disadvantages

- Is not tooth colored; alloy is yellow
- Conducts heat and cold; may irritate sensitive teeth
- High cost; requires at least two office visits and laboratory services

DENTAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1550, Sacramento, CA 95815
www.dbc.ca.gov

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5/04

The Facts About Fillings

The Facts About Fillings

DENTAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1550, Sacramento, CA 95815
www.dbc.ca.gov

Dental Materials Fact Sheet

What About the Safety of Filling Materials?

Patient health and the safety of dental treatments are the primary goals of California's dental professionals and the Dental Board of California. The purpose of this fact sheet is to provide you with information concerning the risks and benefits of all the dental materials used in the restoration (filling) of teeth.

The Dental Board of California is required by law* to make this dental materials fact sheet available to every licensed dentist in the state of California. Your dentist, in turn, must provide this fact sheet to every new patient and all patients of record only once before beginning any dental filling procedure.

As the patient or parent/guardian, you are strongly encouraged to discuss with your dentist the facts presented concerning the filling materials being considered for your particular treatment.

* *Business and Professions Code 1648.10-1648.20*

Allergic Reactions to Dental Materials

Components in dental fillings may have side effects or cause allergic reactions, just like other materials we may come in contact with in our daily lives. The risks of such reactions are very low for all types of filling materials. Such reactions can be caused by specific components of the filling materials such as mercury, nickel, chromium, and/or beryllium alloys. Usually, an allergy will reveal itself as a skin rash and is easily reversed when the individual is not in contact with the material.

There are no documented cases of allergic reactions to composite resin, glass ionomer, resin ionomer, or porcelain. However, there have been rare allergic responses reported with dental amalgam, porcelain fused to metal, gold alloys, and nickel or cobalt-chrome alloys.

If you suffer from allergies, discuss these potential problems with your dentist before a filling material is chosen.

PORCELAIN (CERAMIC)

Porcelain is a glass-like material formed into fillings or crowns using models of the prepared teeth. The material is tooth-colored and is used in inlays, veneers, crowns and fixed bridges.

Advantages

- Very little tooth needs to be removed for use as a veneer; more tooth needs to be removed for a crown because its strength is related to its bulk (size)
- Good resistance to further decay if the restoration fits well
- Is resistant to surface wear but can cause some wear on opposing teeth
- Resists leakage because it can be shaped for a very accurate fit
- The material does not cause tooth sensitivity

Disadvantages

- Material is brittle and can break under biting forces
- May not be recommended for molar teeth
- Higher cost because it requires at least two office visits and laboratory services

NICKEL OR COBALT-CHROME ALLOYS

Nickel or cobalt-chrome alloys are mixtures of nickel and chromium. They are a dark silver metal color and are used for crowns and fixed bridges and most partial denture frameworks.

Advantages

- Good resistance to further decay if the restoration fits well
- Excellent durability; does not fracture under stress
- Does not corrode in the mouth
- Minimal amount of tooth needs to be removed
- Resists leakage because it can be shaped for a very accurate fit

Disadvantages

- Is not tooth colored; alloy is a dark silver metal color
- Conducts heat and cold; may irritate sensitive teeth
- Can be abrasive to opposing teeth
- High cost; requires at least two office visits and laboratory services
- Slightly higher wear to opposing teeth

GLASS IONOMER CEMENT

Glass ionomer cement is a self-hardening mixture of glass and organic acid. It is tooth-colored and varies in translucency. Glass ionomer is usually used for small fillings, cementing metal and porcelain/metal crowns, liners, and temporary restorations.

Advantages

- Reasonably good esthetics
- May provide some help against decay because it releases fluoride
- Minimal amount of tooth needs to be removed and it bonds well to both the enamel and the dentin beneath the enamel
- Material has low incidence of producing tooth sensitivity
- Usually completed in one dental visit

Disadvantages

- Cost is very similar to composite resin (which costs more than amalgam)
- Limited use because it is not recommended for biting surfaces in permanent teeth
- As it ages, this material may become rough and could increase the accumulation of plaque and chance of periodontal disease
- Does not wear well; tends to crack over time and can be dislodged

RESIN-IONOMER CEMENT

Resin ionomer cement is a mixture of glass and resin polymer and organic acid that hardens with exposure to a blue light used in the dental office. It is tooth colored but more translucent than glass ionomer cement. It is most often used for small fillings, cementing metal and porcelain metal crowns and liners.

Advantages

- Very good esthetics
- May provide some help against decay because it releases fluoride
- Minimal amount of tooth needs to be removed and it bonds well to both the enamel and the dentin beneath the enamel
- Good for non-biting surfaces
- May be used for short-term primary teeth restorations
- May hold up better than glass ionomer but not as well as composite
- Good resistance to leakage
- Material has low incidence of producing tooth sensitivity
- Usually completed in one dental visit

Disadvantages

- Cost is very similar to composite resin (which costs more than amalgam)
- Limited use because it is not recommended to restore the biting surfaces of adults
- Wears faster than composite and amalgam

Toxicity of Dental Materials

Dental Amalgam

Mercury in its elemental form is on the State of California's Proposition 65 list of chemicals known to the state to cause reproductive toxicity. Mercury may harm the developing brain of a child or fetus.

Dental amalgam is created by mixing elemental mercury (43-54%) and an alloy powder (46-57%) composed mainly of silver, tin, and copper. This has caused discussion about the risks of mercury in dental amalgam. Such mercury is emitted in minute amounts as vapor. Some concerns have been raised regarding possible toxicity. Scientific research continues on the safety of dental amalgam. According to the Centers for Disease Control and Prevention, there is scant evidence that the health of the vast majority of people with amalgam is compromised.

The Food and Drug Administration (FDA) and other public health organizations have investigated the safety of amalgam used in dental fillings. The conclusion: no valid scientific evidence has shown that amalgams cause harm to patients with dental restorations, except in rare cases of allergy. The World Health Organization reached a similar conclusion stating, "Amalgam restorations are safe and cost effective."

A diversity of opinions exists regarding the safety of dental amalgams. Questions have been raised about its safety in pregnant women, children, and diabetics. However, scientific evidence and research literature in peer-reviewed scientific journals suggest that otherwise healthy women, children, and diabetics are not at an increased risk from dental amalgams in their mouths. The FDA places no restrictions on the use of dental amalgam.

Composite Resin

Some Composite Resins include Crystalline Silica, which is on the State of California's Proposition 65 list of chemicals known to the state to cause cancer.

It is always a good idea to discuss any dental treatment thoroughly with your dentist.

DENTAL AMALGAM FILLINGS

Dental amalgam is a self-hardening mixture of silver-tin-copper alloy powder and liquid mercury and is sometimes referred to as silver fillings because of its color. It is often used as a filling material and replacement for broken teeth.

Advantages

- Durable; long lasting
- Wears well; holds up well to the forces of biting
- Relatively inexpensive
- Generally completed in one visit
- Self-sealing; minimal-to-no shrinkage and resists leakage
- Resistance to further decay is high, but can be difficult to find in early stages
- Frequency of repair and replacement is low

Disadvantages

- Refer to "What About the Safety of Filling Materials"
- Gray colored, not tooth colored
- May darken as it corrodes; may stain teeth over time
- Requires removal of some healthy tooth
- In larger amalgam fillings, the remaining tooth may weaken and fracture
- Because metal can conduct hot and cold temperatures, there may be a temporary sensitivity to hot and cold.
- Contact with other metals may cause occasional, minute electrical flow

The durability of any dental restoration is influenced not only by the material it is made from but also by the dentist's technique when placing the restoration. Other factors include the supporting materials used in the procedure and the patient's cooperation during the procedure. The length of time a restoration will last is dependent upon your dental hygiene, home care, and diet and chewing habits.

COMPOSITE RESIN FILLINGS

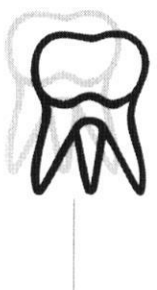
Composite fillings are a mixture of powdered glass and plastic resin, sometimes referred to as white, plastic, or tooth-colored fillings. It is used for fillings, inlays, veneers, partial and complete crowns, or to repair portions of broken teeth.

Advantages

- Strong and durable
- Tooth colored
- Single visit for fillings
- Resists breaking
- Maximum amount of tooth preserved
- Small risk of leakage if bonded only to enamel
- Does not corrode
- Generally holds up well to the forces of biting depending on product used
- Resistance to further decay is moderate and easy to find
- Frequency of repair or replacement is low to moderate

Disadvantages

- Refer to "*What About the Safety of Filling Materials*"
- Moderate occurrence of tooth sensitivity; sensitive to dentist's method of application
- Costs more than dental amalgam
- Material shrinks when hardened and could lead to further decay and/or temperature sensitivity
- Requires more than one visit for inlays, veneers, and crowns
- May wear faster than dental enamel
- May leak over time when bonded beneath the layer of enamel



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Notice of Privacy Practices

Health Insurance Portability and Accountability Act (HIPAA)

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

Western University of Health Sciences is the teaching and practice location for the health professional schools of Western University of Health Sciences and its faculty members. It includes Western University Medical Center, Western Diabetes Institute, Eye Care Institute at WesternU, The Dental Center at WesternU, We Care Dental WesternU, School Based Dental Clinics, Western University Foot & Ankle Center, Western University Limb Preservation Center, Western University Pharmacy and Western University Travel Health Center.

All patient care provided at any of the College of Dental Medicine Clinics is provided by a team of dental students, dental residents, dental faculty and other health care professionals.

This Notice of Privacy Practices applies to your health care information and records maintained at the CDM Clinics.

WHO MUST ABIDE BY THIS NOTICE? All CDM Clinic employees, healthcare providers/faculty and students providing care, and healthcare staff authorized to enter information into your medical or health record.

- Selected CDM Clinic employees responsible for payment and operational support.
- All providers that the above named individuals contract with to provide healthcare services.

All of the above-named individuals will follow the terms of this Notice. In addition, all of the above may share medical information with each other for treatment, payment, or health care operations purposes as described in this Notice.

OUR COMMITMENT REGARDING YOUR MEDICAL INFORMATION each CDM Clinic documents the care and services you receive in written and electronic records. In this Notice, we will refer to those records as "medical information." We need this information to provide you with quality health care and customer service; evaluate benefits and claims; administer health care coverage; measure performance; and, to fulfill legal and regulatory requirements. We understand that medical information about you and your health is personal. We are committed to protecting your medical information and following all state and federal laws related to the protection of your medical information. This Notice tells you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

- make sure that medical information that identifies you is kept private (with certain exceptions);
- give you this Notice describing our legal duties and privacy practices with respect to medical information about you;
- follow the terms of the Notice that are currently in effect.

HOW WE MAY USE OR DISCLOSE YOUR MEDICAL INFORMATION Sometimes, we are allowed by law to use and disclose your medical information without your permission. We briefly describe these uses and disclosures and give you some examples. Some medical information, such as certain mental health and drug and alcohol abuse patient information, and HIV and genetic tests have stricter requirements for use and disclosure, and your permission will be obtained prior to some uses and disclosures. However, there are still circumstances in which these types of information may be used or disclosed without your permission. How much medical information is used or disclosed without your permission will vary depending on the intended purpose of the use or disclosure. When we send you an appointment reminder, for example, a very limited amount of medical information will be used or disclosed. At other times, we may need to use or disclose more medical information such as when we are providing medical treatment.

FOR TREATMENT, We may use medical information about you to provide you with treatment or services. We may disclose medical information about you to healthcare providers, nurses, therapists, technicians, interns, medical students, residents or other health care personnel who are involved in taking care of you, including offering you medical advice, or to interpreters needed in order to make your treatment accessible to you. For example, a healthcare provider may use the information in your medical record to determine what type of medications, therapy, or procedures are appropriate for you. The treatment plan selected by your healthcare provider will be documented in your record so that other health care professionals can coordinate the different things you need, such as prescriptions, lab tests, referrals, etc. We also may disclose medical information about you to people outside our facilities who may be involved in your continuing medical care, such as skilled nursing facilities, other health care providers, case managers, transport companies, community agencies, family members, and contracted/affiliated pharmacies.

TO OBTAIN PAYMENT FOR HEALTH CARE SERVICES We may use and disclose your medical information so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company, or other third party payer. For example, we may need to give your health plan information about a treatment you received so your health plan will pay us. We may also tell your health plan about a proposed treatment to determine whether your plan will cover the treatment or medication. We may also share your information, when appropriate, with other government programs such as Medicare or Medi-Cal in order to coordinate your benefits and payments. We may use or disclose medical information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits. We may also provide your medical information to our business associates who assist us with billing, such as billing companies, claims processing companies and others that process our health care claims. We will only disclose the minimum amount of information needed to obtain payment.

FOR HEALTH CARE OPERATIONS We may use and disclose medical information about you for certain health care operations. For example, we may use your medical information to review the quality of the treatment and services we provided, to educate our health care professionals, and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services we should offer, or whether certain new treatments are effective. Your medical information may also be used or disclosed for licensing or accreditation purposes. We may use and disclose health information about you to carry out necessary insurance-related activities. Examples include, underwriting, premium rating, conducting or arranging medical review, legal and audit services, fraud and abuse detection, business planning, management, and general administration.

FOR REMINDERS We may contact you to remind you that you have an appointment, or that you should make an appointment at the CDM Clinic.

FOR HEALTH-RELATED BENEFITS & SERVICES We may contact you about benefits or services that we provide. We will not sell or give your information to an outside agency for the purposes of marketing their products to you.

FOR TREATMENT ALTERNATIVES We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

FOR FUND-RAISING We may contact you to provide information about raising money for the CDM Clinics and its operations through a foundation related to the CDM Clinics. We would only use demographic information, such as your name, address, phone number, and the dates you received treatment or services at Western University of Health Sciences, CDM Clinic. If you do not want us to contact you for fund-raising efforts, write to Western University of Health Sciences, University Advancement, 359 E. Second St., Pomona, CA 91766.

TO FAMILY AND OTHERS WHEN YOU ARE PRESENT Sometimes a family member or other person involved in your care will be present when we are discussing your medical information. If you object, please tell us and we won't discuss your medical information, or we will ask the person to leave.

TO FAMILY AND OTHERS WHEN YOU ARE NOT PRESENT There may be times when it is necessary to disclose your medical decision-making capacity to agree or object. In those instances, we will use our professional judgment to determine if it is in your best interest to disclose your medical information. If so, we will limit the disclosure to the medical information that is directly relevant to the person's involvement with your health care. For example, we may allow someone to pick up a prescription for you.

FOR RESEARCH: Research of all kinds may involve the use or disclosure of your medical information. Your medical information can generally be used or disclosed for research without your permission if an Institutional Review Board (IRB) approves such use or disclosure. An IRB is a committee that is responsible, under federal law, for reviewing and approving human subject's research to protect the safety and welfare of the participants and the confidentiality of medical information. Your medical information may be important to further research efforts and the development of new knowledge. For example, a research study may involve a chart review to compare the outcomes of patients who received different types of treatment. We may disclose medical information about you to researchers preparing to conduct a research project. On occasion, researchers contact patients regarding their interest in participating in certain research studies. Enrollment in those studies can only occur after you have been informed about the study, had an opportunity to ask questions, and indicated your willingness to participate by signing a consent form.

AS REQUIRED BY LAW We will disclose medical information about you when required to do so by federal, state, or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY We may use and disclose your medical information if a serious and imminent threat to your health or safety or someone else's exists. Any disclosure would be to someone able to help stop or reduce the threat.

FOR DISASTER RELIEF We may disclose your name, city where you live, age, sex, and general condition to a public or private disaster relief organization to assist disaster relief efforts, and to notify your family about your location and status, unless you object at the time.

FOR ORGAN AND TISSUE DONATION If you are an organ or tissue donor, we may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ-donor bank, as necessary to facilitate organ or tissue donation and transplantation.

FOR MILITARY ACTIVITY AND NATIONAL SECURITY We may sometimes use or disclose the medical information of armed forces personnel to the applicable military authorities when they believe it is necessary to properly carry out military missions. We may also disclose your medical information to authorized federal officials as necessary for national security and intelligence activities or for protection of the president and other government officials and dignitaries.

FOR WORKERS' COMPENSATION We may release medical information about you to workers' compensation or similar programs, as required by law. For example, we may communicate your medical information regarding a work-related injury or illness to claims administrators, insurance carriers, and others responsible for evaluating your claim for workers' compensation benefits.

FOR PUBLIC HEALTH DISCLOSURES We may use or disclose medical information about you for public health purposes. These purposes generally include the following:

- to prevent or control disease (such as cancer or tuberculosis), injury, or disability;
- to report births and deaths;
- to report suspected child abuse or neglect, or to identify suspected victims of abuse, neglect, or domestic violence;
- to report reactions to medications or problems with products or medical devices;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to comply with federal and state laws that governs workplace safety.

FOR HEALTH OVERSIGHT ACTIVITIES as health care providers, we are subject to oversight by accrediting, licensing, federal, and state agencies. These agencies may conduct audits on our operations and activities, and in that process, they may review your medical information.

FOR LAWSUITS AND OTHER LEGAL ACTIONS In connection with lawsuits, or other legal proceedings, we may disclose medical information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other lawful process. We may disclose your medical information to courts, attorneys, and court employees in the course of conservatorship and certain other judicial or administrative proceedings. We may also use and disclose your medical information, to the extent permitted by law, without your consent to defend a lawsuit.

FOR LAW ENFORCEMENT If asked to do so by law enforcement, and as authorized or required by law, we may release medical information:

- to identify or locate a suspect, fugitive, material witness, or missing person;
- about a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death suspected to be the result of criminal conduct;
- about criminal conduct at one of our facilities; and
- in case of a medical emergency, to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

TO CORONERS AND FUNERAL DIRECTORS We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

INMATES If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution for certain purposes, for example, to protect your health or safety or someone else's. Note: Under the federal law that requires us to give you this Notice, inmates do not have the same rights to control their medical information as other individuals.

ALL OTHER USED AND DISCLOSURES OF YOUR MEDICAL INFORMATION REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. Please note that the revocation will not apply to any authorized use or disclosure of your medical information that took place before we received your revocation. Also, if you gave your authorization to secure a policy of insurance, including health care coverage from us, you may not be permitted to revoke it until the insurer can no longer contest the policy issued to you or a claim under the policy.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION Your medical information is the property of the Medical Center. You have the following rights, however, regarding your medical information, such as your medical and billing records. This section describes how you can exercise these rights.

RIGHT TO INSPECT AND COPY With certain exceptions, you have the right to see and receive copies of your medical information that was used to make decisions about your care, or decisions about your health plan benefits. If you would like to see or receive a copy of such a record, please write us at the address where you received care. If you don't know where information to a family member or other person involved in your care is located, please write us at The Dental center at Western University of Health Sciences, ATTN: Director of Patient Care Services, 795 E. Second St., Pomona, CA 91766-2007. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. If we don't have the record you asked for but we know who does, we will tell you who to contact to request it. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, in most cases, you may have the denial reviewed. Another licensed health care professional chosen by the CDM Clinic will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

RIGHT TO CORRECT OR UPDATE YOUR INFORMATION If you feel that your medical information is incorrect or important information is missing, you may request that we correct or add to (amend) your record. Please write to us and tell us what you are asking for and why we should make the correction or addition. Submit your request to The Dental Center at Western University of Health Sciences Director of Patient Care Services, 795 E. Second St., Pomona, CA 91766-2007. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us;
- is not a part of the medical information kept by or for us;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete in the record.

We will let you know our decision within 60 days of your request. If we agree with you, we will make the correction or addition to your record. If we deny your request, you have the right to submit an addendum, or piece of paper written by you, not to exceed 250 words, with respect to any item or statement you believe is incomplete or incorrect in your record. If you clearly indicate in writing that you want the addendum to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

RIGHT TO AN ACCOUNTING OF DISCLOSURES You have the right to receive a list of the disclosures we have made of your medical information. An accounting or list does not include certain disclosures, for example, disclosures to carry out treatment, payment, and health care operations; disclosures that occurred prior to January 1, 2010; disclosures, which you authorized us in writing to make; disclosures of your medical information made to you; disclosures to persons acting on your behalf. To request this list or accounting of disclosures, you must submit your request in writing to the Western University of Health Sciences CDM Clinic, 795 E. Second St., Pomona, CA 91766-2007. Your request must state the time period to be covered, which may not be longer than six years and may not include dates before **April 14, 2003**. You are entitled to one disclosure accounting in any 12-month period at no charge. If you request any additional accountings less than 12 months later, we may charge a fee.

RIGHT TO REQUEST LIMITS ON USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. However, by law, we do not have to agree to your request. Because we strongly believe that this information is needed to appropriately manage the care of our patients, we rarely grant such a request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to The Dental Center at Western University of Health Sciences, ATTN: Director of Patient Care Services, 795 E. Second St., Pomona, CA 91766-2007. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

RIGHT TO CHOOSE HOW WE SEND MEDICAL INFORMATION TO YOU: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only phone you at work or use a P.O. Box when we send mail to you. To request confidential communications, you must make your request in writing, specify how or where you wish to be contacted, and submit it to The Dental Center at Western University of Health Sciences, ATTN: Director of Patient Care Services, 795 E. Second St, Pomona, CA 91766-2007. When we can reasonably and lawfully agree to your request, we will.

RIGHT TO A PAPER COPY OF THIS NOTICE You have the right to a paper copy of this Notice upon request. This can be done in one of three ways: ask for a copy at the registration area of the Center; write to Western University of Health Sciences CDM Clinic, 795 E. Second St., Pomona, CA 91766-2007; or call at (909) 706-3900. You may also obtain a copy of this Notice of Privacy Practices on our website at: http://www.WesternUPCC.com.

CHANGES TO THIS NOTICE We may change this Notice and our privacy practices at any time, as long as the change is consistent with state and federal law. Any revised Notice will apply to both the medical information we already have about you at the time of the change, and any medical information created or received after the change takes effect. We will post a copy of our current Notice in the Center and on our website at: http://www.WesternUPCC.com. The effective date of the Notice will be on the first page, in the top right-hand corner.

QUESTIONS If you have any questions about this Notice, please contact The Dental Center at Western University of Health Sciences Director of Patient Care Services, 795 E. Second St., Pomona, CA 91766-2007. The Office for Civil Rights has established a toll-free "privacy line" to enable the public to ask questions related to the privacy regulations. The privacy line can be reached at 1-866-627-7748 or you can call 1-415-437-8310.

COMPLAINTS If you believe your privacy rights have been violated; you may file a complaint with any of the following:

- You can write The Dental Center at Western University of Health Sciences, ATTN: Director of Patient Care Services, 795 E. Second St., Pomona, CA 91766-2007, or call (909) 469-8616.
- You may file a written complaint with the secretary of the Department of Health & Human Services. Instructions on how to file a complaint can be found on the Office for Civil Rights website at: http://www.hhs.gov/ocr/office/file/index.html
- You can call the Federal Office for Civil Rights in San Francisco at (415) 437-8310 or (800) 368-1019.

We will not take retaliatory action against you if you file a complaint about our privacy practices.

This Patient Rights document incorporates the requirements of the
45 CFR § 164.520(a)(1) and
42 C.F.R. Section 482.13 (Medicare Conditions of Participation).