ROANOKE VALLEY ORTHODONTICS

Dr. David L. Jones &
Dr. Maston R. McCorkle

540.563.1640 | info@roanokevalleyortho.com

PATIENT REGISTRATION AND HEALTH HISTORY

Name:_____Nickname:_____Sex:___ Age: _____Birthdate:_____

Address:_____City_____State:_____Zip:_____

Home Phone:_____ Cell Phone: _____ E-mail address:_____

Whom may we thank for referring you? _____

Has the patient had previous orthodontic treatment? ____ YES ____ NO If yes, by whom _____ & when _____

Has anyone else in your family sought orthodontic treatment in our office? ____ YES ____ NO If yes, who _____

Who will be responsible for payment of the account? _____ Father _____ Mother _____ Both _____ Self ____ Other?

Emergency contact, other than parent or guardian _____ Phone: _____

School attending? _____ Grade/Year _____

PATIENTS UNDER AGE 18

Father's Name _____

Father's Spouse (if applicable) _____

Father's Address _____

Father's Work No. _____ Cell _____

Father's Email _____

Father's SSN _____

Occupation_____

Place of Employment _____

Mother's Name _____

Mother's Spouse (if applicable) _____

Mother's Address _____

Mother's Work No. _____ Cell _____

Mother's Email _____

Mother's SSN _____

Occupation_____

Place of Employment _____

Parent Divorced or Separated? _____ YES _____ NO
If yes, who is the custodial parent? _____

ADULT PATIENTS

Patient's Work No._____ Cell _____

Occupation _____

Place of Employment _____

Patient's SSN_____

Spouse's Name _____

Spouse's Work No._____ Cell _____

Occupation _____

Place of Employment _____

Other Responsible Party (Step-Parent, Grandparent, …)

Name _____

Address _____

City, State, Zip _____

Work No._____ Cell _____

Occupation_____

Place of Employment _____

PATIENT'S DENTAL HISTORY

Family Dentist _____ Date of last dental checkup _____Reason for checkup_____

Why does the patient need orthodontic treatment? _____

Has the patient had any of the following habits: Sucking finger ___Y ___N Thumb ___Y ___N Lip ___Y ___N

How severe? _____ How long? _____When? (night only, etc.) _____

ROANOKE VALLEY ORTHODONTICS

Dr. David L. Jones &
Dr. Maston R. McCorkle

540.563.1640 | info@roanokevalleyortho.com

Periodontal disease (pyorrhea)? ___Yes ___No If yes, who is treating the condition? _____

Injury to face, or tooth or root canal treatment? _____ Yes _____ No If yes, explain _____

Clicking or pain in the jaw joint? _____ Yes _____ No Limited opening or locking of the jaw? _____ Yes _____ No Headaches, dizziness or ringing in the ears? _____ Yes _____ No

Speech problems? _____ Yes _____ No Please explain _____

Patient's attitude toward brushing? _____ Excellent _____ Good _____ Average _____ Fair _____ Poor

Patient's attitude toward dentistry? _____ Excellent _____ Good _____ Average _____ Fair _____ Poor

Patient's attitude toward orthodontics? _____ Excellent _____ Good _____ Average _____ Fair _____ Poor

What type of student is the patient in school? _____ Excellent _____ Good _____ Average _____ Fair _____ Poor

How do you think the patient will cooperate with orthodontic treatment? ___Excellent ___Average ___ Poor

Other orthodontic problems in the family? _____ Yes _____ No If yes, were they treated? _____

PATIENT'S MEDICAL HISTORY

Physician's Name _____ Date of last physical _____

Reason _____

Patient's General Health _____ Excellent _____ Good _____ Average _____ Fair _____ Poor

Heart Murmur or other condition? ___ Yes ____ No If yes, is medication required for dental visits? ___ Yes ___ No Please explain_____

Does the patient have any of the following?:

Asthma _____ Yes _____ No

AIDS, herpes, or HIV+ _____ Yes _____ No

Autism _____ Yes _____ No

ADD/ADHD _____ Yes _____ No

Blood transfusion _____ Yes _____ No

Diabetes _____ Yes _____ No

Emotional problems _____ Yes _____ No

Epilepsy _____ Yes _____ No

Hepatitis _____ Yes _____ No

Hyperactivity _____ Yes _____ No

Rheumatic Fever _____ Yes _____ No

Other _____

Please explain any "YES" above: _____

Is the patient on any regular medications or taking any medications now? _____ Yes _____ No

Please list and explain: _____

Are there any allergies or drug sensitivities? _____ Yes _____ No (if yes, please give specifics below):

Medications _____ Hay Fever _____

Food _____ Latex gloves _____ Nickel _____

Are tonsils and adenoids present? _____ Yes _____ No

Does the patient snore or have any difficulty breathing through the nose? _____ Yes _____ No

Any digestion, swallowing, or eating problems? _____ Yes _____ No If so, please explain _____

For females- Is the patient pregnant? _____ Yes _____ No If yes, how far along? _____

SIGNATURE _____**Date** _____

(Parent or Guardian, if the patient is a minor)

ROANOKE VALLEY ORTHODONTICS

Dr. David L. Jones &
Dr. Maston R. McCorkle

540.563.1640 | info@roanokevalleyortho.com

Orthodontic Insurance Information

Note: Medical Insurance does not cover orthodontic treatment

Patient Name _____ Date of birth ____/____/____

Primary Policyholder Information

Name: _____ Relationship to Patient: _____

Date of Birth: ____/____/_____ ID# or SS#_____ Group#_____

Employer: _____

Dental Ins. Company: _____ Ins. Phone # (_____) _____ - _____

Ins. Address: _____ City _____ State _____ Zip _____

For Office Use Only

Lifetime Ortho Max- $ _____ Amount used $ _____ Deductible- $ _____ Age Limit _____

Benefits paid _____% at start up to $ _____, then Monthly, Quarterly, or Annually Auto Payments: Yes or No

Payment Notes: _____

Payments to: Office or Subscriber Payer ID: _____ Effective Date: _____

Secondary Policyholder Information

Name: _____ Relationship to Patient: _____

Date of Birth: ____/____/_____ ID# or SS#_____ Group#_____

Employer: _____

Dental Ins. Company: _____ Ins. Phone # (_____) _____ - _____

Ins. Address: _____ City _____ State _____ Zip _____

For Office Use Only

Lifetime Ortho Max- $ _____ Amount used $ _____ Deductible- $ _____ Age Limit _____

Benefits paid _____% at start up to $ _____, then Monthly, Quarterly, or Annually Auto Payments: Yes or No

Payment Notes: _____

Payments to: Office or Subscriber Payer ID: _____ Effective Date: _____

ROANOKE VALLEY
ORTHODONTICS

Dr. David L. Jones &
Dr. Maston R. McCorkle

540.563.1640 | info@roanokevalleyortho.com

Financing and Insurance

We are happy to work with you and your insurance company to receive the maximum benefit possible under your policy. We have found that the more you know about your individual policy, the easier it is to process your claim. To assist us in this endeavor, we have established the following answers to the most commonly asked questions.

Everyone deserves a beautiful smile and we believe the cost of braces should not prevent you from getting that smile. Our goal is to provide you with the most affordable and convenient payment schedule possible and we will work with you to accommodate your needs.

Please keep in mind that our primary financial relationship is with our patients and their families. We realize that understanding your orthodontic insurance can be difficult and we welcome any questions you might have. Thank you in advance for your cooperation in helping us to provide the best and most efficient treatment for our patients.

Payment Options

We offer several payment options to help meet your individual needs.

- Families, who wish to pay in full at the beginning of treatment, receive a discounted fee, as your full payment saves us administrative time and costs.
- Care Credit is accepted for payment in full without a pay in full discount.
- We offer affordable payment plan options. Payment plan options require a down payment and then monthly payments that are automatically drafted from your checking, savings or credit card accounts.
- In order to make monthly payments more convenient, we offer automatic withdrawals (from checking, savings, and credit card accounts) at no additional cost to you.
- We accept MasterCard, Visa, and Discover for down payments.
- Cash and checks are also accepted for down payments.

Insurance
Many insurance plans cover a portion of the fees. You will need to bring a copy of your insurance card to our office so that we may properly submit your claim forms.

How does orthodontic insurance work?
There are many different agreements between insurance carriers and their subscribers, and each policy provides a different benefit. Orthodontic insurance differs from regular dental insurance in that it rarely pays for orthodontic treatment in full. Each insured individual usually has a lifetime maximum benefit for orthodontic services. This benefit is paid as a percentage of the orthodontic fee until the maximum has been reached. Charges for lost or broken appliances may not be covered by insurance.

How will our office assist you with your insurance?
We will generate an insurance form on our computer that describes the orthodontic problems, the required treatment, the length of treatment time and the financial arrangement. We will file a pre-estimate to your insurance company before treatment starts (however, this is not a guarantee of payment). Once treatment begins, we will file a claim for the orthodontic treatment. The insurance company will then send us payments based on their own fee schedule. If the insurance companies require follow up claims or verification of treatment, we will submit those as needed.

Should the insurance company not send us the payments directly; we will need the families to reimburse our office for the insurance portion of the contract. I.e. – sometimes the insurance company will not pay our office and will send the families the checks. If we have a separate insurance contract, the checks must be signed over to our office in order to pay the insurance portion of the contract.

How can you maximize your benefit?
Know what your benefits are before treatment begins. If you are not sure, contact your insurance company or your employers human resources department so that you know exactly how much you can expect them to pay. Should your insurance company deny treatment or insurance coverage change, you will then be responsible any amount not paid by your insurance company. Please remember that **you** are ultimately responsible for all charges incurred in our office.

ROANOKE VALLEY
ORTHODONTICS

Dr. David L. Jones &
Dr. Maston R. McCorkle

540.563.1640 | info@roanokevalleyortho.com

Authorization Form

Please read each authorization request and circle either "**Yes**" or "**No**" on the line and then sign the bottom of the form. You have the right to revoke these authorizations in writing at any time; however, any information already received will not be covered under that revocation. You also have a right to a copy of any information we have provided.

PATIENT (S)_____

___Yes/No__ I request and give my permission to Roanoke Valley Orthodontics to provide copies of all orthodontic records with the respect to the orthodontic care of the above mentioned patient(s) to other dental offices and insurance companies. Such records may include, but not be limited to, medical care and treatment, illness or injury, dental and orthodontic history, medical history, financial history, consultation, prescriptions, x-rays and models.

___Yes/No___ I authorize the release of any information from other treating dental offices regarding the dental history and/ or treatment of patients(s) above, to Roanoke Valley Orthodontics, for the purpose of verifying, evaluating or treating the above mentioned patient(s).

___Yes/No___ I authorize Roanoke Valley Orthodontics to publish photographs taken of me for use in:

(Check any you agree to)

_____ Inner-office photos
_____ Office publications
_____ Social media sites such as Facebook
_____ Office website
_____ Marketing
_____ Orthodontic publications

__Yes/No___ I acknowledge and agree that publication of photographs confers no rights of ownership or royalties whatsoever. I hereby release Roanoke Valley Orthodontics and any third parties involved in the creation or publication of marketing materials from liability for any claims by me or a third party in connection with my participation. I do not expect any compensation for the use of these photographs.

__Yes/No____ I authorize Roanoke Valley Orthodontics and OrthoIntouch, our Automated Texting and Emailing System, to send appointment reminders and other orthodontic related reminders, including those with messages, to my cell phone, any other cell numbers and email I provided on the Patient History Form.

____YES_____ I authorize Roanoke Valley Orthodontics to take photographs, slides, videos and or x-rays of my face, jaws, mouth and teeth, before, during, and after treatment. I understand that these items will be used as a record of my care and may be used for educational purposes in study club meetings, lectures, seminars, and demonstrations. I further understand that if these items are used in any way, my name or other identifying information will be kept confidential unless I sign a release. (This is required as part of treatment)

_____ _____

Signature of Responsible Party Date

ROANOKE VALLEY
ORTHODONTICS

Dr. David L. Jones &
Dr. Maston R. McCorkle

540.563.1640 | info@roanokevalleyortho.com

INFORMED CONSENT

ORTHODONTIC TREATMENT PRODUCES SIGNIFICANT IMPROVEMENT FOR PATIENTS. THE BENEFITS OF A PLEASING SMILE AND HEALTHY TEETH ARE WIDE APPRECIATED. HOWEVER, ORTHODONTIC TREATMENT IS AN ELECTIVE PROCEDURE. THERE ARE SOME UNAVOIDABLE RISKS AND LIMITATIONS YOU SHOULD BE AWARE OF BEFORE STARTING TREATMENT.

LACK OF PATIENT COOPERATION- THE MOST COMMON CAUSE OF PROLONGED TREATMENT AND POOR RESULTS
Practicing good oral hygiene, keeping regular appointments, wearing elastics, appliances, or headgear, and avoiding improper foods are all essential for a good result. Failure to cooperate will result in a compromised result, extend treatment, and result in additional expense.

TOOTH SCARRING- DECALCIFICATION AND DECAY
Poor tooth brushing and excessive sugar in the diet will produce permanent scarring and staining of the teeth and can require restorations (fillings). Proper brushing, flossing, limiting sugar in the diet, and reporting any loose braces will help prevent scarring.

HEADGEAR-INSTRUCTIONS MUST BE FOLLOWED CAREFULLY
The elastic force must be released before the headgear is removed or it can snap back and cause severe injury to the mouth, face, or eyes. The headgear should not be worn during rough play or sports that might cause falls or collisions.

IMPACTED TEETH-TEETH UNABLE TO ERUPT NORMALLY
In attempting to move impacted teeth, especially canines, various problems are sometimes encountered which may lead to damage or loss of the tooth or adjacent teet Also, problems with the supporting bone and gum tissue may develop. Rarely, these teeth will not move.

DEAD TEETH-USUALLY TEETH THAT HAVE BEEN INJURED
Teeth can die over a long period of time with or without orthodontic treatment and require root canal therapy. Teeth with fillings, or a oral history of trauma are more likely to be affected.

SHORTENING OF ROOTS-ROOT RESORPTION
The roots of teeth can become shorter with or without orthodontic treatment. Under healthy conditions the shortened roots usually are no problem, but can result in tooth loss. Accidental injury, surgical procedures, impaction, medical disorders, or unknown reasons can cause this problem.

POST TREATMENT TOOTH MOVEMENT-RELAPSE
Teeth will shift or settle after treatment and retention. Some changes may be desirable, but others will not. Rotations and crowding of the front teeth are common. Slight spaces where teeth were removed can remain. Proper retainer wear prevents relapse.

UNFAVORABLE FACIAL GROWTH-POOR JAW RELATIONSHP
The position of the jaws in relationship to each other determines how well the teeth can fit together. If the jaws do not develop in a favorable position, the orthodontic result can be compromised. Unfavorable growth of the jaws before, during, or after treatment may necessitate surgery to correct the bite.

TEMPOROMANDIBULAR JOINT (TMJ)-JAW JOINTS
Popping, clicking, locking, and pain can develop in the jaw joint and surrounding structures. These symptoms may exist before, during, or after orthodontic treatment. While tooth position or bite problems may contribute to these symptoms; non-dental factors such as psychological stress, arthritis, injury, or structural problems can als be involved. Clenching or grinding the teeth may also be associated. Orthodontic treatment may or may not correct TMJ symptoms.

GUM DISEASE-PERIODONTAL DISEASE, LOSS OF BONE AROUND THE TEETH
Periodontal disease results in the loss of support for the teeth and may exist before, during, or after orthodontics. A periodontics or dentist must evaluate patients with periodontal disease before orthodontics can be started. Good oral hygiene can help control periodontal disease, but gum and bone support can sometimes be lost during orthodontic treatment, and teeth can be lost.

APPLIANCE REMOVAL
When removing bonded brackets or bands, enamel flaking or fracturing can occur. This risk is highest for teeth with large restorations or root canals, which tend to weaken the enamel.

UNUSUAL OCCURRENCES-VERY RARELY ORTHODONTIC APPLIANCES, DENTAL RESTORATIONS, OR CHIPPED TEETH CAN BE SWALLOWED OR ASPIRATED AND COULD REQUIRE EMERGENCY MEDICAL TREATMENT.

DENTAL CHECK-UPS
All required dental work must be completed before orthodontics can begin. Patients must continue to visit their regular dentist while undergoing orthodontic treatmen
IF YOU HAVE ANY QUESTIONS ABOUT ANY OF THE ABOVE, PLEASE ASK DR. M. R.McCORKLE OR DR. DAVID L. JONES

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have ready or had read to me the contents of this forms and do realize the risks and limitations involved, and do consent to orthodontic treatment.

I have read and understand the above and consent to treatment of :

_____
Patient's Name

_____
Patient - Parent - Guardian Signature

_____
Date

ROANOKE VALLEY
ORTHODONTICS

Dr. David L. Jones &
Dr. Maston R. McCorkle

540.563.1640 | info@roanokevalleyortho.com

Roanoke Valley Orthodontics

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment – dated Sept 23rd, 2013

I, _____, have received a copy of this
(Please Print – Patient, Parent/Legal Guardian if under 18)

Office's Notice of Privacy Practices.

_____
Patient's Name

_____
Patient (or Responsible Party) Signature

_____
Date

For Office Use Only

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

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

ROANOKE VALLEY ORTHODONTICS
Dr. David L. Jones &
Dr. Maston R. McCorkle
540.563.1640 | info@roanokevalleyortho.com

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.

We are required by law to maintain the privacy of protected health information (PHI) (i.e., individually identifiable information, such as names dates, phone/fax numbers, e-mail addressed, home addresses, Social Security numbers, and demographic data), to provide individuals with notice of our legal duties and privacy practices with respect o protect health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09.23.2013, and will remain in effect until we replace it.

We reserve the right to make our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. Form 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your protected health information (PHI) for different purposes, including treatment, payment and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state and federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your PHI for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your PHI to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to o obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your PHI in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your PHI to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health history information.

Disaster Relief. We may use or disclose your PHI to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your PHI for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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

Secretary of HHS. We will disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by their requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their

duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you don not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

With a few exceptions, we are required to obtain authorization from you before any disclosure of psychotherapy notes that might be in our files or for the use of disclosure of you PHI for marketing. We will not sell your PHI. We will obtain your written authorization from you before using or disclosing you PHI for purposes other than those provided in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures to your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12- month period, we may charge you a reasonable, cost-based fee for

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (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. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handles under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend you health information. Your request must be in writing, and it must explain why the information should be amended. We may deny y our request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and ex0plain your rights.

Right to Notification of a Breach. Your will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our We site or by electronic mail (e-mail).

Questions and Complains

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

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complain with the U.S. Department of Heath and Human Servicers upon request.

We support your right opt 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.

Our Privacy Official: Dr. M. R. McCorkle, Jr., D. D. S or David L. Jones, D.D.S.

Telephone: 540.563.1640 or 540.483.7946 Fax: 540.563.5157

Address: 6220 Peters Creek Road NW or 490 South Main Street or 4370 Starkey Road, Suite C

City, State: Roanoke, VA 24019 Rocky Mount, VA 24151 Roanoke, VA 2018

E-mail: info@roanokevalleyortho.com