ATLANTIS DENTAL CARE, P.A. 5851 S. CONGRESS AVENUE. ATLANTIS.FLORIDA.33462
Ph: 561-965-9988 Fax: 561-965-0385 Email: **AtlantisDental@comcast.net**
www.AtlantisDentist.com

WELCOME TO OUR OFFICE

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial:____

Date of Birth: _____ Age: _____ Preferred Name: _____

Patient is: Policy Holder Y/N Responsible Party Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cellular: _____ Home: _____ Work: _____

BEST NUMBER AND TIMES TO REACH YOU: _____

Email: _____

Marital Status: _____ Sex: _____

Driver's License #: _____

INSURANCE INFORMATION

Name of Insured: _____Relationship: Self / Spouse / Child / Other

Insured SSN #: _____ Insured Date of Birth: _____

Employer: _____

Insurance Company: _____ Group Name: _____

Insurance Phone #: _____ Member ID: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____Relation: _____ Phone#: _____

GETTING TO KNOW YOU

How did you hear about our office? _____

Names of other family members who are patients here? _____

When was your last dental visit? _____ Reason: _____

PATIENT SIGNATURE: _____ DATE:_____

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MEDICAL DR.NAME:_____ PHONE: _____ FAX:_____

PREFERRED PHARMACY NAME:_____ PHONE: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Pregnant/Trying to get ◯ Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____

****

OFFICE USE ONLY

REVIEWING DENTIST SIGNATURE: _____ DATE: _____

Medical clearance Needed or Not? Premedication Needed or Not? Amoxicillin 2gms? / Clindamycin 3mg ?one hour before the appointment.

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CONSENT FOR TREATMENT

We are here to provide dental service to you in the most beneficial way possible. This requires much understanding. In order to educate and inform you, we would like you to read this consent for treatment.

_____ Initial
I realize that unless I provide the doctor with an accurate and complete medical and dental history, complications may result. I am aware that the dentist may need to confer with my physician. I agree to provide all information. I will notify the office if there is any change in my medical status.

_____ Initial
I understand that certain parts of my treatment may be performed by licensed, supervised paraprofessionals other than the dentist. I thus consent to treatment by those paraprofessionals.

_____ Initial
I understand that x-rays, photographs or models of my mouth may be necessary for an accurate diagnosis and treatment. I understand that these are the property of the doctor, but that copies are available on request at an additional cost. I consent to the use of these diagnostic tests unless I so state prior to their implementation.

_____ Initial
I recognize that in cleaning teeth the dentist or paraprofessional may use a modern and efficient method known as ultrasonic cleaning. I understand that other electronic and mechanical devices will also be used in my treatment. I consent to such procedures unless I object to the use of such equipment in a timely fashion. I am aware that pacemakers are sensitive to some of this equipment and I will immediately inform all personnel if I have a pacemaker.

_____ Initial
I realize that in the course of treatment, drugs and medications may be used. I realize that any risks concerned with drugs will be explained to me, If I have questions, I will ask. I know that occasionally a reaction may occur to these drugs or local anesthetics. I understand that some risks may be involved and that if I have any questions concerning their use, I should discuss this with the doctor. I realize that if I am experiencing any adverse reactions to drugs, medication or treatment, I should immediately advise the doctors or their assistants.

_____ Initial
I understand that the doctor is not responsible for previously placed dental appliances or previous dental treatment. I understand that, in the course of treatment, these previously made dental appliances or other existing dentistry may need adjustment, cost will be explained first.

_____ Initial
I know that I should listen carefully when the dentist advises me of any change in the plan of treatment which may result in adjustments of treatment, change in fee or time involved. I realize that alternative treatment plans, if any, will be discussed with me prior to my acceptance of treatment.

_____ Initial
I agree that fees are payable when the service is rendered unless specific financial arrangements are made prior to dental treatment. Arrangements are made with the office manager.

_____ Initial
I realize that guarantees of results or absolute satisfaction are not possible in dental health service. I realize that personal articles brought into the office are my responsibility.

I have read and understand the contents of this treatment and agree to the provisions of it. If I have any questions I will ask the doctor.

Patient Name (print)_____

Signature_____Date_____

Signature of Parent or Guardian (for minor child) _____Date_____

THANK YOU.

Your cooperation, consent for treatment and open communication will greatly add to your dental success and it will make working toward our mutual goals much easier.

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AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION
(Email and Texting Permission)

Patient Name:_____ Date of Birth:_____

I agree that the dental practice may communicate with me electronically at the email address and/or texting number below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I can withdraw my consent to electronic communications by calling: **561-965-9988**

Email Address (please print clearly): _____

Texting Cell Number (please print clearly): _____

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AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
PERMISSION TO USE INFORMATION

** You May Refuse to Sign This Acknowledgment **

I _____, have received a copy of this office's Notice of Privacy Practices. I give this office my permission to use my health information for treatment, payments, and health care operations only.

I _____, refuse to sign this acknowledgment and wish to discuss this with the Office Manager.

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PERMISSION TO SPEAK TO THE FOLLOWING PEOPLE
In this permission we seek to give you a family atmosphere!

I_____, authorize Atlantis Dental Care, P.A. STAFF to speak or share my dental health records, emergency contact, and account (including balance owed and appointment information) to the following people:

Name: _____Relation: _____Contact by:
Email: _____and/or Phone: _____or Verbally.

Name: _____Relation: _____Contact by:
Email: _____and/or Phone: _____or Verbally

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

STAFF NAME & SIGNATURE: _____ DATE: _____

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FINANCIAL POLICY

Our commitment is to help remove financial misunderstandings or barriers, so that our patients can receive the dental treatment they need and desire. Your clear understanding of our policies plays and important role in our relationship. Please ask if you have any questions about our fees, financial and scheduling policy, or your responsibility.

*Insurance: Our experienced team is committed to helping patients maximize their dental benefits. Insurance policies vary greatly. Due to the complexity of insurance contracts we can only **ESTIMATE** in good faith, what your insurance will pay, not guarantee your coverage. Your estimated patient portion must be paid at the time the service is rendered, unless prior financial arrangements have been made. As a service to our patients, we will bill your insurance company for services, allowing 30 days for them to render payment. After 30 days, you are responsible for the entire balance due in full. If you have any questions, our courteous office staff is always available to answer them for you. You will be informed of treatment planned and associated fees.

*Your Responsibility: Keeping us informed of changes in your health, medications, address, dental insurance, contact information, account information and any information that helps us manage your care.

*Payment options: We accept cash, checks, debit and most credit cards (Master Card, Visa, Discover, and American Express). We also offer flexible financing options through 3rd Party Financing because we understand that monthly payments can help patients fit the cost of dental treatment into their budgets.

*3rd Party Financing: We offer financing through vendors for those who qualify. With these institutions, you can finance up to 100% of your dental treatment with no upfront costs, no annual fees, and no pre-payment penalties. The vendors, Care Credit and Lending Club offer a full range of payment plans, so you can find the one that works best for you. It can be used by the whole family for ongoing treatment without having to reapply.

*Service Charges: The policy of this office is to charge 1.5% monthly interest (18% annual percentage rate) or billing charge that will be applied to all accounts over 90 days past due. We will also charge **$35.00** for any returned checks.

*Collection Fees: Fees incurred to collect payment, will be billed to and payable by the patient's account holder.

*Assignment of Benefits: I hereby authorize assignment of payment of my dental insurance benefits to **ATLANTIS DENTAL CARE,P.A**.

*Financial Agreements: The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office. I understand and agree to this financial policy.

Patient/Responsible Party Name	Signature	Date

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SCHEDULING POLICY

We value time, yours and ours. Please understand the we reserve room time, Doctor & staff time just for you when you make an appointment. In an effort to continually provide quality care and service please keep your reserved time as scheduled. Our office needs 48 business hours notification if you need to change or cancel your reserved time.

Notification to change or cancel appointment times: You can reach us by:
phone: 561-965-9988
email: AtlantisDental@comcast.net

We schedule one patient per appointment because you deserve exclusive personal time with your doctor and staff. We strive to run on time so you will not be kept waiting, and we ask that you try to arrive on time for your appointment as well. We understand you are busy, and your time is valuable to us. We pride ourselves on keeping to our schedule and only deviate from it in the event of situations outside of our control.

Not Showing Up for Appointment: We want to work with you to schedule convenient appointments for your visits to our office. However, we ask that you please call two business days in advance, if you need to cancel & reschedule your appointment. Missed appointments without this notification, will incur NO SHOW fees of **$ 150.00** per hour of your scheduled appointment time. We understand emergency situations, please inform us of these situations. After missed or not showing up on appointment we will place you on a call list. This means, if we have an opening you will be called. We are committed to your dental health.

Canceling and Rescheduling: We understand changes happen, and work with you on these changes. Repeated cancellations and rescheduling does impact our time,and your dental care. We shall discuss this with you should it interfere with your dental care and our time. Without a 48 hour notice, you will incur a cancellation fee of **$ 150.00.**

Reservation Fee: At our discretion for appointments, we will require a deposit of 20% of total treatment fee. This deposit will be applied to your treatment rendered. However, if you cancel or reschedule or not show up with less than 48 hours notice to us, then the deposit will be used as cancellation fee of $150.00 per hour.

On our part: We will call and email you if we have any scheduling changes due to emergencies on our part, giving you time to change the appointment time. On non-emergency situations, we will give you 48 hours to change the appointment.

I understand and accept the scheduling policy.

_____	_____	_____
Patient / Responsible Party Name	Signature	Date

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New Patient Questionnaire

Patient Name: _____

I entered this practice to obtain: (Please check all that apply)

☐ **Comprehensive Exam** of my entire mouth and a consultation concerning my treatment options.

☐ **Smile Design Consultation** to learn more about my cosmetic treatment options.

☐ **Emergency Exam** for a specific area of concern. **Are you in pain?** ____Yes ____ No
Please describe:_____
_____
_____

☐ **2nd opinion** concerning treatment options presented elsewhere.

☐ **Other.** Please explain:_____
_____

I would rate the value I place on my oral health as:
_____ Very Important to me
_____ Moderately important to me
_____ Very low importance to me

I would rate the condition of my teeth and gums:
_____ Very good
_____ Good
_____ Acceptable
_____ In need of treatment
_____ In need of a lot of treatment

I would rate my previous dental experiences and quality of care as:
_____ Exceptional
_____ Above average
_____ Average
_____ Below Average
_____ Poor

I have concerns in pursing future dental treatment: _____ Yes _____ No

My concerns are:
_____ I am fearful of dental treatment.
Please explain: _____
_____ Financial
_____ Scheduling concerns
Please explain: _____
_____ Other:
Please explain: _____

I consider my smile:
_____ Very appealing
_____ Nice
_____ Acceptable to me
_____ In need of improvement

Is there any further information about you that would help us to assist you more thoroughly?

_____
_____
_____
_____

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Notice of Privacy Practices *PATIENT COPY*

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, to provide individuals with notice of our legal duties and privacy practices with respect to protected 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 10/01/2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, 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. 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information 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 or 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 health information 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 health information 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 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 health information 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 health information 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 information.

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

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

Public Health Activities. We may disclose your health information 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 health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information 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 the 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 do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI
Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for 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. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. 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 of 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 responding to the additional requests.

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 handled 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 your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. 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 explain your rights.

Right to Notification of a Breach. You 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 Web site or by electronic mail (e-mail).

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

If you are concerned that we may have violated your privacy rights, or 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 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.

Our Privacy Official: DR. YAGI K. PATEL

Telephone: 561-965-9988 **Address:**5851 SOUTH CONGRESS AVE. ATLANTIS. FL. 33462 **Fax:** 561- 965-0385

E-mail: AtlantisDental@comcast.net