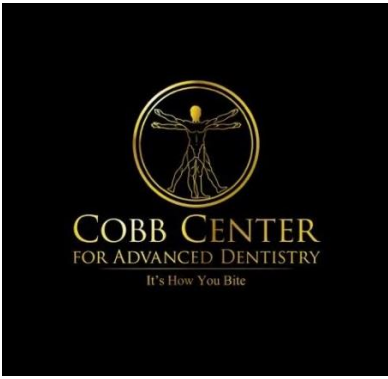




Sanjay Patel, D.M.D.

Patient Name: _____ **Prefer to be called:** _____

Female **Male** **Date of Birth** ____/____/____ **SSN#** ____/____/____ **Marital Status:** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Cell: _____ **Home:** _____ **Email:** _____

Employer _____ **Work Phone:** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Emergency Contact: _____ **Phone** _____ **Relationship** _____

Responsible Party: _____ **Phone** _____ **Relationship** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Female **Male** **Date of Birth** ____/____/____ **SSN#** ____/____/____ **Marital Status:** _____

Insurance Company: _____ **Phone** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Subscriber ID# _____ **Group#** _____

Are you currently under the care of a physician: **Yes** **No** **Dr. Name** _____ **Phone** _____

If yes, for what condition _____

Have you had surgery within the past 6 weeks: **Yes** **No** **Explain:** _____

Are you currently taking prescription or over the counter drugs or herbal supplements: **Yes** **No**

Are you on an Aspirin therapy regime: **Yes** **No** If yes please Explain: **81 mg/day** or other _____

Are you currently on any blood thinning therapy: **Yes** **No** If yes please Explain: _____

Do you take Ginger, Ginseng, Ginko Biloba or Garlic: **Yes** **No** If yes please list which ones: _____

Please list all medications you are currently taking. Please include all prescribed medications as well as any over the counter medications:

Name of Medication	Dosage (mg.)	Frequency (1/day, 2/day)	Prescribing Doctor	Phone #

Special circumstances we should be aware of:

Do you have Allergies to any of the following:

Aspirin	Yes	No	Local Anesthetic	Yes	No	Latex	Yes	No
Codeine	Yes	No	Penicillin	Yes	No	Sulfa	Yes	No
Erythromycin	Yes	No	Antibiotics	Yes	No	Barbiturates	Yes	No
Sleeping Pills	Yes	No	Sedatives	Yes	No	Plastic	Yes	No
Iodine	Yes	No	Metals	Yes	No			

Other: _____

Are you currently a patient at a pain management group: **Yes** **No** Reason: _____

Group Name: _____ Phone: _____

Do you require Oral Premedication with antibiotics before dental treatment: **Yes** **No**

If yes for what condition: _____ Medication _____ Dosage _____

Have you ever taken any of the groups of drugs collectively known as "fen-phen": **Yes** **No** When: _____

Were you medically cleared of any heart issues: **Yes** **No** Was there heart damage: **Yes** **No**

Please explain if yes: _____

Do you or have you ever used:

Tobacco Yes No If yes please list frequency: _____

Alcohol Yes No If yes please list frequency: _____

Recreational Drugs Yes No If yes please list frequency: _____

When was your last dental appointment: _____ Reason: _____

Do you have a history of gum disease: **Yes** **No** Was it treated with Deep Cleaning or Surgery: **Yes** **No**

Please circle either Y if you have had or N if you have not had any of the following:

Aids/HIV	Yes	No	Anemia	Yes	No	Arthritis	Yes	No
Artificial Heart Valves	Yes	No	Artificial Joints	Yes	No	Asthma	Yes	No
Back Problems	Yes	No	Bleeding Issues	Yes	No	Blood Disease	Yes	No
Cancer	Yes	No	Chemotherapy	Yes	No	Circulatory	Yes	No
Cortisone Treatment	Yes	No	Cough Persistent	Yes	No	Coughing Bloody	Yes	No
Diabetes	Yes	No	Drug Addiction	Yes	No	Emphysema	Yes	No
Epilepsy	Yes	No	Fainting/Dizziness	Yes	No	Glaucoma	Yes	No
Heart Lesions	Yes	No	Headache/Migraine	Yes	No	Heart Murmur	Yes	No
Heart Problems	Yes	No	Hepatitis Type ____	Yes	No	Herpes	Yes	No
High Blood Pressure	Yes	No	Jaundice	Yes	No	Jaw Pain	Yes	No
Kidney Disease	Yes	No	Liver Disease	Yes	No	Nervous Issues	Yes	No
Low Blood Pressure	Yes	No	Mitral Valve Disease	Yes	No	Pacemaker	Yes	No
Psychiatric Care	Yes	No	Radiation Treatment	Yes	No	Rheumatic Fever	Yes	No
Respiratory Disease	Yes	No	Scarlet Fever	Yes	No	Skin Rash	Yes	No
Shortness of Breath	Yes	No	Sinus Trouble	Yes	No	Special Diet	Yes	No
Swollen feet or ankles	Yes	No	Swollen Glands	Yes	No	Stroke	Yes	No
Thyroid Problems	Yes	No	Tumor Growth on head	Yes	No	Tonsillitis	Yes	No
Ulcers	Yes	No	Venereal Disease	Yes	No	Weight Loss	Yes	No
Adnoids Removed	Yes	No	Anemia	Yes	No	Arteriosclerosis	Yes	No
Autoimmune Disorders	Yes	No	Bleeding Easily	Yes	No	Bruising Easily	Yes	No
Chronic Fatigue	Yes	No	Cold Hands and Feet	Yes	No	Dizziness	Yes	No
Difficulty Concentrating	Yes	No	Excessive Thirst	Yes	No	Fluid retention	Yes	No
Frequent cough	Yes	No	Frequent Illness	Yes	No	Hypoglycemia	Yes	No
Frequent stressful situations	Yes	No	Fibromyalgia	Yes	No	Gout	Yes	No
Hearing Impairment	Yes	No	Heart Palpitations	Yes	No	Hemophilia	Yes	No
Immune System Disorder	Yes	No	Insomnia	Yes	No	Liver Disease	Yes	No
Intestinal disorders	Yes	No	Jaw Joint Surgery	Yes	No	Menieres Disease	Yes	No
Menstrual Cramps	Yes	No	Multiple Sclerosis	Yes	No	Muscle Aches	Yes	No
Muscle Shaking	Yes	No	Muscle Spasms	Yes	No	Muscle Cramps	Yes	No
Muscular Dystrophy	Yes	No	Nervous System Irritability	Yes	No	Nervousness	Yes	No
Neuralgia	Yes	No	Osteoarthritis	Yes	No	Osteoporosis	Yes	No
Ovarian Cysts	Yes	No	Parkinsons Disease	Yes	No	Poor Circulation	Yes	No
Braces	Yes	No	Radiation Treatment	Yes	No	Skin Disorder	Yes	No
Shortness of breath	Yes	No	Slow Healing sores	Yes	No	Speech Difficulties	Yes	No
Swollen, stiff or painful joints	Yes	No	Tired Muscles	Yes	No	Tumors	Yes	No
Urinary Disorders	Yes	No	Wisdom Teeth Removal	Yes	No			
Injury to:			Tendency for:			Other:	_____	
Face	Yes	No	Frequent Colds	Yes	No	_____		
Neck	Yes	No	Ear Infections	Yes	No	_____		
Mouth	Yes	No	Sore Throats	Yes	No	_____		
Teeth	Yes	No						

This section is for women only

Are you currently pregnant	Yes	No	If yes what week ____	Dr. Name _____
Are you Nursing	Yes	No		
Are you taking Birth Control	Yes	No		Phone _____

To better coordinate your treatment, please list the medical professionals you have consulted regarding your present symptoms. Please be sure to list your primary physician and family dentist if not Dr. Patel

 Please initial if you want us to send them a report from your visit.

Patient Name: _____ **Date:** _____

Family Physician

Name: _____
Address: _____

Phone: _____

Dentist

Name: _____
Address: _____

Phone: _____

Chiropractor

Name: _____
Address: _____

Phone: _____

Physical Therapist

Name: _____
Address: _____

Phone: _____

ENT - Allergist

Name: _____
Address: _____

Phone: _____

Cardiologist

Name: _____
Address: _____

Phone: _____

Pulmonologist

Name: _____
Address: _____

Phone: _____

Neurologist

Name: _____
Address: _____

Phone: _____

Psychiatrist

Name: _____
Address: _____

Phone: _____

Psychologist

Name: _____
Address: _____

Phone: _____

Other

Name: _____
Address: _____

Phone: _____

Pain Management Group

Name: _____
Address: _____

Phone: _____

_____ I understand and agree to have the indicated professionals I have listed above be sent initial information and ongoing updates regarding my diagnoses and treatment.

_____ I do not wish to have my records sent at this time.

DATE _____

Patient or Guardian Signature _____

Head, Neck and Facial Pain Questionnaire

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please number your complains with the 1 being most severe symptom, 2 the next, etc.
2. Then rate your complaints for frequency and intensity:

1 - Seldom 2 - Occasional 3 – Frequent 4 – Every Day

3. Intensity: 0 = No Pain 5 = Bad but can function 10 = MOST SEVERE PAIN

Number		Frequency	Intensity
_____	Back Pain	_____	_____
_____	Dizziness	_____	_____
_____	Ear Congestion	_____	_____
_____	Ear Pain	_____	_____
_____	Eye Pain	_____	_____
_____	Facial Pain	_____	_____
_____	Fatigue	_____	_____
_____	Headaches	_____	_____
_____	Inability to open mouth	_____	_____
_____	Jaw Clicking	_____	_____
_____	Jaw Joint Noises	_____	_____
_____	Jaw Locking	_____	_____
_____	Jaw Pain	_____	_____
_____	Limited Mouth Opening	_____	_____
_____	Migraine Headaches	_____	_____
_____	Muscle Twitching	_____	_____
_____	Neck Pain	_____	_____
_____	Pain when chewing	_____	_____
_____	Ringing In the Ears	_____	_____
_____	Shoulder Pain	_____	_____
_____	Sinus Congestion	_____	_____
_____	Throat Pain	_____	_____
_____	Visual Disturbances	_____	_____
_____	Other: _____	_____	_____

Fill In

Date: _____

Signature of patient completing form

Please list any treatments you have had for this problem:

1. _____ Date _____
 2. _____ Date _____
 3. _____ Date _____

Symptoms: Please indicate location and type of pain.

Jaw Symptoms

Jaw Clicks	Yes	No	Jaw Locks Closed	Yes	No	Jaw Popping	Yes	No
Jaw Locks Open	Yes	No	Teeth Clenching	Yes	No	Teeth Grinding	Yes	No

Eye Related Conditions

Blurred Vision	Yes	No	Double Vision	Yes	No	Eye Pain	Yes	No
Pain or pressure behind the eyes	Yes	No	Photophobia	Yes	No			

Ear Related Conditions

Buzzing in ears	Yes	No	Ear Congestion	Yes	No	Ear Pain	Yes	No
Hearing Loss	Yes	No	Pain behind ear	Yes	No	Tinnitus	Yes	No
Pain in front of ear	Yes	No	Recurrent Ear Infections	Yes	No			

Throat, Neck and Back Related Conditions

Back Pain - Lower	Yes	No	Chronic Sore Throat	Yes	No	Neck Pain	Yes	No
Back Pain - Middle	Yes	No	Difficulty Swallowing	Yes	No	Limited Movement	Yes	No
Back Pain - Upper	Yes	No	Scoliosis	Yes	No	Sciatica	Yes	No
Numbness in hands or fingers	Yes	No	Shoulder Stiffness	Yes	No	Swollen Glands	Yes	No
Swelling in Neck	Yes	No	Thyroid Enlargement	Yes	No	Wryneck	Yes	No
Tightness in Throat	Yes	No	Tingling in hands fingers	Yes	No			

Mouth and Nose Related

Broken Teeth	Yes	No	Burning Tongue	Yes	No	Dry Mouth	Yes	No
Chronic Sinusitis	Yes	No	Frequently biting Cheek	Yes	No	Frequent Snoring	Yes	No

Please Indicate Location and Type of Any Head Pain: L = Left R = Right B = Both Sides

Head Pain	Location	SEVERITY			FREQUENCY			DURATION				
		MILD	MODERATE	SEVERE	Monthly	Weekly	Daily	Seconds	Minutes	Hours	Days	Weeks
L R B	Front of head (Frontal)	0	0	0	0	0	0	0	0	0	0	0
L R B	Entire Head (Generalized)	0	0	0	0	0	0	0	0	0	0	0
L R B	Top of Head (Parietal)	0	0	0	0	0	0	0	0	0	0	0
L R B	Back of Head (Occipital)	0	0	0	0	0	0	0	0	0	0	0
L R B	In the Temples (Temporal)	0	0	0	0	0	0	0	0	0	0	0

Jaw Pain

L R B Jaw Pain – On Opening
 L R B Jay Pain – While Chewing
 L R B Jay Pain – At Rest

History of Symptoms

When did you condition first occur?: _____

Do you believe is the cause of your pain or condition?

___ Motor Vehicle Accident	___ Motorcycle Accident	___ Work Related Incident
___ Athletic Endeavor	___ Playground Incident	___ Fight
___ Fall	___ Accident	___ Illness
___ Injury	___ Unknown	___ Other: _____

If accident, date: _____

Is there anything that makes your pain or discomfort worse? _____

Is there anything that makes your pain or discomfort better?: _____

What other information is important to your pain or condition?" _____

Family History

Have any members of your family (blood kin) had:

___ Headaches ___ Heart Disease ___ High Blood Pressure ___ Diabetes

Social History

Occupation: _____ Is your job stressful: **Yes** **No**

Do you have children: **Yes** **No** If so how many: _____ What are their ages?: _____

Are you currently under unusual stress **Yes** **No** If a smoker how much per day?: _____

Recent change in lifestyle **Yes** **No** Caffeine drinks per day?: _____

Do you Chew Tobacco **Yes** **No** Alcohol consumption: _____

Do you exercise regularly? **Yes** **No** ___ None ___ Daily ___ Social Drinker ___ Occasional Only

History of Accident: If you were involved in an accident or a traumatic incident, complete this section

Date of Incident or accident: _____

WERE YOU?

___ A passenger in a vehicle
___ The driver of a vehicle
___ A Pedestrian
___ At work

AND...

___ Did you fall
___ Were you hit by an object
___ Did you hit an object
___ Other: _____

Indicate if there was any direct trauma:

DID YOUR

___ Forehead
___ Face
___ Chin
___ Side of head
___ Back of head
___ Top of head
___ Teeth
___ Jaw
___ Roof
___ Other: _____

FORCIBLY STRIKE

___ Steering Wheel
___ Windshield
___ Passengers side window
___ Drivers side window
___ Passengers side door
___ Drivers side door
___ Headrest
___ Seat
___ Interior of car
___ Other: _____

Were any areas of your body painful shortly after the accident/incident?

☐ Head	☐ Neck	☐ Face	☐ Right Arm
☐ Jaw	☐ Left Shoulder	☐ Right Shoulder	☐ Left Arm
☐ Lower Back	☐ Upper Back	☐ Other: _____	

Did you go to the Hospital?: **Yes** **No** Which Hospital?: _____

By Car **Yes** **No** Were X-Rays taken **Yes** **No**

By Ambulance **Yes** **No** Release date: _____

Has a Doctor ever diagnosed a TMJ or TMD disorder prior to the accident? **Yes** **No**

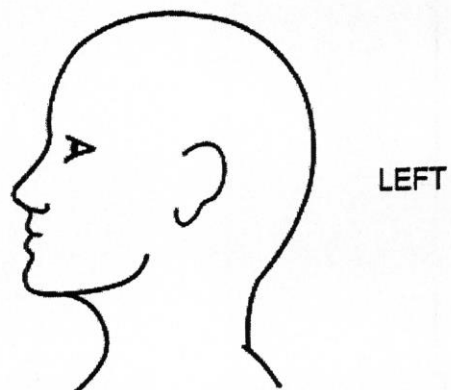
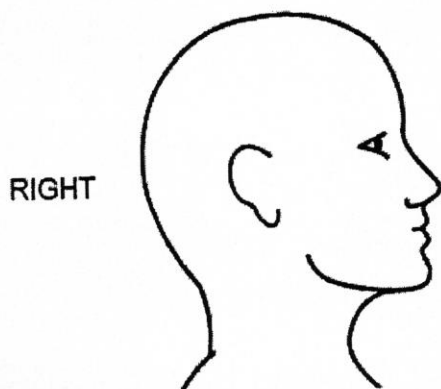
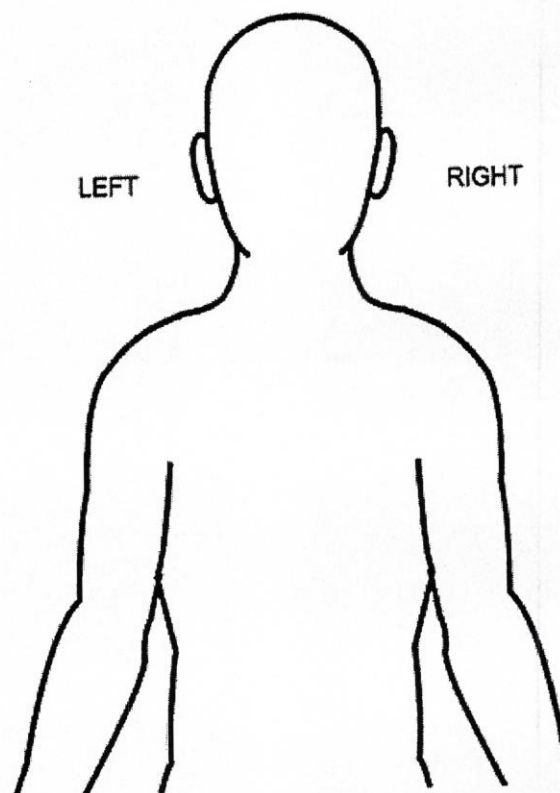
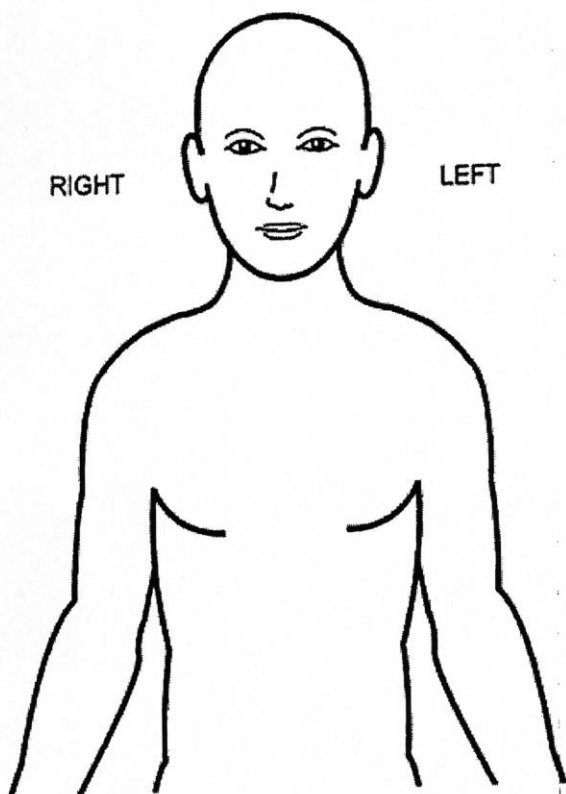
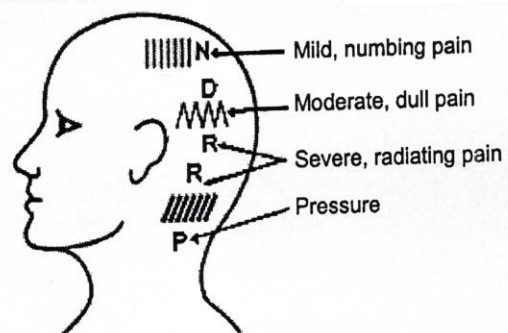
If yes, please explain: _____

Signature: _____ **Date:** _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN		B Burning
		D Dull
		N Numbing
MODERATE PAIN		P Pressure
		S Sharp
SEVERE PAIN		T Tingling
		R Radiating

EXAMPLE



Patient Signature _____

Date _____

Acknowledgement of receipt of notice of Privacy Practices

- You may refuse to sign this acknowledgement

I, _____, have received a copy of this offices Notice of Privacy Practices

Printed Name

Signature

Date

(Please initial either giving permission or not giving permission below)

Name

Phone Number/Email

Relationship

_____	_____	_____
_____	_____	_____
_____	_____	_____

I give permission to Cobb Center for Advanced Dentistry to discuss my case, health and care, in emergency and nonemergency instances, via phone, in person or via email and mail posted USPS with the following:

OR

I do not give permission any information regarding my case, health and care to be discussed with any person except my dental insurance provider and other medical professionals involved in my treatment.

For Office Use Only Do not write below this line

We attempted to obtain written acknowledgement from the patient that they did receive a copy of the Notice of Privacy Practice, but were unable to due to:

_____ The individual refused to sign
_____ Communication barriers prevented obtaining the acknowledgement
_____ Emergency situation prevented us from obtaining the acknowledgement
_____ Other (Please Detail Situation) _____

Date

Signature



Cobb Center for Advanced Dentistry

Sanjay Patel, D.M.D.

3325 Shallowford Road
Suite 520,
Marietta, GA 30062

Telephone: 770-578-1331
Fax: 770-578-1325
frontdeskC4AD@gmail.com

Itshowyoubite.com

06/23/2026

Office and Financial Policies

(Please initial or sign where indicated)

Payment Responsibility

Payment for all services is due at the time they are rendered unless prior arrangements have been made. Patients are responsible for all fees not covered by insurance, including deductibles, co-pays, non-covered services, and balances remaining after insurance payment.

Insurance Filing

As a **COURTESY**, we will file your dental insurance claims. Insurance benefits are an agreement between you and your insurer; we cannot guarantee payment. Any portion not paid by insurance within **45 days** becomes the patient's responsibility.

It is the responsibility of the patient to monitor claims on the insurance patient portal or any communications from the insurance company: Request, EOB's, delays in processing, etc.

It is the responsibility of the patient to keep the office updated on any changes in policy coverage.

Accepted Forms of Payment

We accept cash, debit, major credit cards, HAS/FSA cards, and approved third-party financing. Please understand the card processing company charges a 3% processing fee on credit card charges. This amount is the processing companies fee and in no way benefits CC4AD. There is no fee charged on debit cards, FSH and HAS cards.

Late Fee for Past-Due Balances

If a balance remains unpaid **30 days** after the statement date and an arrangement has not been coordinated with the front office, a **late fee of \$35 or 2.5% of the unpaid balance per month** (whichever is greater) will be added. This fee represents a **reasonable estimate of administrative costs** associated with managing delinquent accounts and **is not a finance charge or interest**.

It is the responsibility of the patient to contact the office regarding balances and payments.

Accounts more than **90 days** past due may be referred to collections. Patients are responsible for all collection costs, including reasonable attorney’s fees as permitted by Georgia law.

Returned Checks

Returned checks are subject to a **\$35 returned-check fee**, consistent with Georgia Code § 13-6-15. Future payments may be required in Cash

Payment Plans

Payment plans may be available for certain treatments. All payment-plan terms must be in writing and signed by the patient or responsible party.

Missed or Late-Cancelled Appointments

Appointments cancelled or missed with less than **24 hours’ notice** may incur a **missed-appointment fee**. This fee is not covered by insurance. Fees are as follows:

1 Hour appointment	\$ 50.00
2 Hour Appointment	\$100.00
3+ Hour Appointments	\$300.00

Appointment Confirmation

CC4AD will attempt to contact you via automated text and emails 1 week, then 2 days prior to your scheduled appointment to confirm your visit. Respond with your confirmation by texting “C” This will stop the Multiple reminders that occur due to not responding with the “C”. If you are unable to respond via text or email, you will need to call CC4AD by 10:00 A.M. the business day before the appointment – otherwise the appointment will be canceled and marked as a “no-show”.

Always Arrive 5-10 Minutes Early When you schedule an office visit with us, we request you to arrive at our practice 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and or to complete any necessary paperwork before the scheduled visit.

Acknowledgement of understanding

By signing below, you acknowledge that you have read, understand, your responsibilities as indicated above.

Printed Name

Date

Signature

It is our Mission to:

1. Expect and ensure optimal dental health and general wellness for our patients for life.
2. To provide the highest possible quality and value of dental care, with courtesy and professionalism.
3. To deliver this care in a happy, welcoming and protective environment with integrity and empathy.
4. To accept our patients as partners in their wellness through education, motivation and open communication.
5. To respect our patients' time.
6. To provide the patient with the most comfortable, fear-free and pain-free treatment possible and make their dental visits a pleasurable experience.
7. To consistently provide exceptional service and deliver more than you expect.
8. To pursue excellence through continuing education, personal and team growth, and mastery of cutting-edge technology.
9. To flourish through patient satisfaction and subsequent recommendations to their friends and family. If you ever feel that we are not living up to our mission, please feel free to bring it to our attention.

Oral Cancer Screening Consent Form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause for both the incidence and mortality rates of oral cancer to continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors.** Oral cancer risk by patient profile is as follows:

Increased Risk: Patients ages 18-39

High Risk: Patients age 40 and older; tobacco users (any age, any type within 10 years)

Highest Risk: Patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer

We have recently incorporated Velscope® into our oral screening standard of care. We find that using Velscope along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. Velscope is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. Velscope is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The Velscope exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however, this exam may not be covered by your insurance.

The fee for this enhanced examination is \$83.00 this is not covered by your dental insurance.

Yes, I authorize the clinician to perform the Velscope exam,
along with the standard oral cancer examination.

I accept financial responsibility for this enhanced examination.

Signature: _____ Date: _____

OR

No, I would prefer not have the Velscope exam done at this time.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (4/1/02), 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health

information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

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

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.50 for each page, \$30 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, costbased fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have a right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic (e-mail), you are entitled to receive this Notice in written form.

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 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 may also 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.

Contact Officer: Beckysue Jackson
Telephone: 770-578-1331
Fax: 770-578-1325
Address: 3225 Shallowford Rd.
Ste. 520,
Marietta, GA 30062