

Welcome to the office of Dr. Karen Ho!

Patient Name _____

Date _____

Patient Information

Street Address _____ City/State _____ Zip Code _____

Home Phone _____ Mobile Phone _____ SS# _____

Email Address _____ Date of Birth _____

If patient is full-time student, name of school _____

Employer _____ Address _____

City/State _____ Zip Code _____ Work Phone _____

In case of emergency, who should be notified? _____ Phone _____

Relationship to patient _____ Physician Name and Phone _____

Whom may we thank for referring you? _____

Primary Insurance

Secondary Insurance (if applicable)

Policy Holder _____

Policy Holder _____

Relation to patient _____ Date of Birth _____

Relation to patient _____ Date of Birth _____

Address (if different than patient) _____

Address (if different than patient) _____

_____ City/State _____

_____ City/State _____

Zip Code _____

Zip Code _____

Policy Holder employed by _____

Policy Holder employed by _____

Address _____

Address _____

City/State _____ Zip Code _____

City/State _____ Zip Code _____

SS# _____ Work Phone _____

SS# _____ Work Phone _____

Insurance Company _____

Insurance Company _____

Group # _____ Subscriber # _____

Group # _____ Subscriber # _____

Office Policy

Your complete dental needs cannot be known until there has been a full diagnosis, including an exam and x-rays. The charge for all initial exams, x-rays, cleanings and emergency care must be paid at the time the service is performed. When the diagnosis is complete, you and the doctor will discuss the service to be performed and the fee for such service. If an extended payment plan is desired, please ask us about the CareCredit program. When satisfactory financial arrangements have been made, the work to be performed can proceed.

You are ultimately responsible for all charges regardless of any existing dental coverage. Co-payments and deductibles are due at the time of service. This office bills your insurance and submits insurance claims as a courtesy to you. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due to our office may be adjusted accordingly. All recommended treatment is determined to be necessary by the doctor. Failure of your insurance company to pay does NOT indicate the treatment can wait nor waive any of our fees. Itemized statements will be mailed to you every 30 days even when we are billing your insurance. If care and treatment are suspended or terminated, any fees for services rendered will be immediately due and payable. All accounts, on reaching 90 days past due, are subject to submission to an outside collection agency if satisfactory payment arrangements have not been made with the billing office.

I authorize any holder of medical information about me to release to the insurance company and its agent any information needed to determine these benefits or the benefits payable for related services. I request that payment of authorized insurance benefits be made to Karen Ho, D.D.S. for any services furnished to me by Karen Ho, D.D.S.

It is our policy to regularly use various pain reducing anesthetic systems. These procedures are performed to enhance a pleasant dental experience. For a patient who may be using any medications, drugs, or chemicals, it is most important to advise the doctor concerning this fact, as this information is vital in evaluating the type of anesthesia to be used while a person has his or her dentistry completed.

Signature of Responsible Party _____ Date _____

Print Name _____

Parents or guardians of minor children must accompany a child or submit written treatment and financial consent at each and every visit.

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 _____
- 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

Women: Are you

Pregnant/Trying to get pregnant? Yes No 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 | Scarlet Fever | Yes No |
| Arthritis/Gout | Yes No | Epilepsy or Seizures | Yes No | High Cholesterol | Yes No | Shingles | Yes No |
| Artificial Heart Valve | Yes No | Excessive Bleeding | Yes No | Hives or Rash | Yes No | Sickle Cell Disease | Yes No |
| Artificial Joint | Yes No | Excessive Thirst | Yes No | Hypoglycemia | Yes No | Sinus Trouble | Yes No |
| Asthma | Yes No | Fainting Spells/Dizziness | Yes No | Irregular Heartbeat | Yes No | Spina Bifida | Yes No |
| Blood Disease | Yes No | Frequent Cough | Yes No | Kidney Problems | Yes No | Stomach/Intestinal Disease | |
| Blood Transfusion | Yes No | Frequent Diarrhea | Yes No | Leukemia | Yes No | | 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 | Tonsilitis | 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 | | Heart Pacemaker | Yes No | Parathyroid Disease | Yes No | Ulcers | Yes No |
| | Yes No | Heart Trouble/Disease | Yes No | Psychiatric Care | Yes No | Venereal Disease | Yes No |
| Convulsions | 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 _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN 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 February 16, 2026 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 use disorder treatment 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 participate 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 perform 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.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

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 acted 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.

Aviso de prácticas de privacidad

ESTE AVISO DESCRIBE LA FORMA EN QUE SE PUEDE UTILIZAR Y DIVULGAR SU INFORMACIÓN DE SALUD Y CÓMO PUEDE ACCEDER A ELLA. REVÍSELO DETENIDAMENTE.

La ley nos exige que mantengamos la privacidad de la información de salud protegida, que informemos a las personas sobre nuestras obligaciones legales y prácticas de privacidad en lo que respecta a la información de salud protegida, y que notifiquemos a las personas afectadas por un acceso no autorizado a la información de salud protegida no asegurada. Debemos seguir las prácticas de privacidad descritas en este aviso mientras esté en vigencia. Este aviso entra en vigencia el 16 de febrero de 2026 y permanecerá vigente hasta que lo reemplacemos.

Nos reservamos el derecho de modificar nuestras prácticas de privacidad y los términos de este aviso en cualquier momento, siempre y cuando esos cambios estén permitidos por la ley vigente, y de que las nuevas disposiciones del aviso entren en vigencia para toda la información de salud protegida que nosotros conservamos. Cuando hagamos un cambio sustancial en nuestras prácticas de privacidad, cambiaremos este aviso y publicaremos el nuevo aviso de manera clara y prominente en nuestro consultorio, y proporcionaremos copias del nuevo aviso si se solicita.

Puede pedir una copia de nuestro aviso en cualquier momento. Para obtener más información sobre nuestras prácticas de privacidad, o si desea copias adicionales de este aviso, utilice la información que se encuentra al final de este documento para ponerse en contacto con nosotros.

CÓMO PODEMOS USAR Y DIVULGAR SU INFORMACIÓN DE

SALUD Podemos usar y divulgar su información de salud para distintos fines, incluido el tratamiento, el pago y las actividades de atención médica. Para cada una de estas categorías, hemos proporcionado una descripción y un ejemplo. Cierta información, como información relacionada con el VIH, información genética, registros de tratamiento de trastornos por consumo de alcohol o sustancias, y los registros de salud mental pueden tener protecciones especiales de confidencialidad conforme a las leyes estatales o federales aplicables. Cumpliremos con estas protecciones especiales en lo que respecta a los casos correspondientes que incluyan estos tipos de registros.

Tratamiento. Podemos usar y divulgar su información de salud para su tratamiento. Por ejemplo, podemos divulgar su información de salud a un especialista que le esté proporcionando tratamiento.

Pago. Podemos usar y divulgar su información de salud para obtener un reembolso por el tratamiento y los servicios que reciba de nosotros u otra entidad involucrada en su atención. Las actividades de pago incluyen facturación, cobranzas, manejo de reclamos y determinaciones de elegibilidad y cobertura a fin de obtener el pago de usted, una compañía de seguros o un tercero. Por ejemplo, podemos enviarle reclamos a su plan dental que incluyan determinada información de salud. **Actividades de atención médica.** Podemos usar y divulgar su información de salud vinculada a nuestras actividades de atención médica. Por ejemplo, las actividades de atención médica que incluyen actividades de evaluación y mejoramiento de la calidad, programas de capacitación y actividades relacionadas con la obtención de licencias.

Personas involucradas en su atención o responsables del pago de su atención. Podemos divulgar su información médica a su familia o amigos, o a cualquier otra persona que usted indique cuando participen en su atención o en el pago de su atención. Además, podemos divulgar su información a un representante de paciente. Si una persona cuenta con autorización legal para tomar decisiones de atención médica por usted, trataremos a ese representante de paciente de la misma manera que lo trataríamos a usted en lo que respecta a su información de salud.

Asistencia en casos de catástrofes. Podemos usar o divulgar su

información de salud para brindar asistencia en actividades de ayuda en casos de catástrofe. **Cuando la ley lo exija.** Podemos usar o divulgar su información de salud cuando la ley exija que lo hagamos.

Actividades de salud pública. Podemos divulgar su información de salud para actividades de salud pública, que incluyen divulgaciones para:

- prevenir o controlar enfermedades, lesiones o discapacidades
- informar la negligencia o el abuso de niños
- informar reacciones a medicaciones o problemas con productos o dispositivos
- notificar a una persona sobre los productos o dispositivos que se retirarán del mercado, repararán o sustituirán
- notificar a una persona que puede haber estado expuesta a una enfermedad o afección
- notificar a la autoridad gubernamental correspondiente si creemos que un paciente ha sido víctima de abuso, negligencia o violencia doméstica

Seguridad nacional. Podemos divulgar la información de salud del personal de las fuerzas armadas a las autoridades militares en determinadas circunstancias. Podemos divulgar la información de salud que los funcionarios federales autorizados requieran para actividades legales de inteligencia, contrainteligencia u otras actividades de seguridad nacional. Podemos divulgar la información de salud protegida de un recluso o paciente a una institución correccional o a una autoridad policial que tenga custodia legal de esa persona. **Secretaría del Departamento de Salud y Servicios Humanos (HHS).** Podemos divulgar su información de salud a la Secretaría del Departamento de Salud y Servicios Humanos de los Estados Unidos cuando lo requiera para investigar o determinar el cumplimiento de la Ley de Portabilidad y Responsabilidad de Seguros Médicos (HIPAA).

Indemnización de trabajadores. Podemos divulgar su información de salud protegida (PHI) en la medida en que sea autorizado y sea necesario para cumplir con las leyes relacionadas con la indemnización de trabajadores u otros programas similares establecidos por la ley.

Cumplimiento de la ley. Podemos divulgar su PHI para fines de cumplimiento de la ley en tanto lo permita la HIPAA, según lo exija la ley, o en respuesta a una citación u orden judicial.

Actividades de control de la salud. Podemos divulgar su PHI a una agencia de control para realizar actividades autorizadas por ley, que incluyen: auditorías, investigaciones, inspecciones y comprobación de credenciales, según sea necesario para otorgar licencias y para que el gobierno supervise el sistema de atención médica, los programas gubernamentales y el cumplimiento de las leyes civiles.

Procedimientos judiciales y administrativos. Si está involucrado en una demanda o una disputa, podemos divulgar su PHI en respuesta a una orden judicial o administrativa. También podemos divulgar su información de salud en respuesta a una citación, petición de pruebas u otro proceso legal iniciado por otra persona involucrada en la disputa, pero solo si se han tomado las medidas necesarias, ya sea de parte de nosotros o de la parte solicitante, para informarle sobre la petición o para obtener una orden de protección de la información solicitada.

Investigación. Podemos divulgar su PHI a investigadores cuando su investigación haya sido aprobada por una junta de revisión institucional o privada que haya analizado la propuesta de investigación y establecido los protocolos para garantizar la privacidad de su información.

Peritos forenses, médicos forenses y directores de funerarias. Podemos divulgar su PHI a un perito o médico forense. Esto puede ser necesario, por ejemplo, para identificar a una persona fallecida o determinar la causa de la muerte. También podemos divulgar la PHI a los directores de funerarias de acuerdo con la ley vigente para que puedan realizar sus tareas. **Recaudación de fondos.** Podemos comunicarnos con usted para brindarle información sobre nuestras actividades patrocinadas, que incluyen programas de recaudación de fondos, según lo permita la ley vigente. Si no desea que le enviemos esa información, puede optar por no recibir las comunicaciones.

Información sobre el tratamiento del trastorno por consumo de sustancias (SUD). Si recibimos o mantenemos información sobre usted de un programa de tratamiento de trastornos por consumo de sustancias que está cubierto por el título 42 del Código de Regulaciones Federales (CFR), Parte 2 (un «programa de la Parte 2») a través de un consentimiento general que usted otorga al programa de la Parte 2 para usar y divulgar el registro del programa de la Parte 2 con fines de tratamiento, pago u operaciones de atención médica, podemos usar y divulgar su registro del programa de la Parte 2 con fines de tratamiento, pago y operaciones de atención médica según se describe en este aviso. Si recibimos o mantenemos su registro del programa de la Parte 2 a través del consentimiento específico que nos proporcione a nosotros o a un tercero, usaremos y divulgaremos su registro del programa de la Parte 2 solo según lo permita expresamente en el consentimiento que brinde. En ningún caso utilizaremos ni divulgaremos su registro del programa de la Parte 2 o un testimonio que describa la información contenida en su registro del programa de la Parte 2, en ningún procedimiento civil, penal, administrativo o legislativo de ninguna autoridad federal, estatal o local, en su contra, a menos que su consentimiento o la orden de un tribunal lo autorice después de que lo notifique la orden judicial.

OTROS USOS Y DIVULGACIONES DE LA PHI

Se requiere su autorización, con algunas excepciones, para la divulgación de notas de psicoterapia, el uso o la divulgación de PHI

para fines de marketing y para la venta de la PHI. También obtendremos su autorización por escrito antes de usar o divulgar su PHI para fines que no sean los descritos en este aviso (o salvo en los casos que lo autorice o exija la ley). Puede revocar una autorización por escrito en cualquier momento. Al recibir la revocación por escrito, dejaremos de usar o divulgar su PHI, excepto en la medida en que ya hayamos actuado en función de la autorización.

SUS DERECHOS EN RELACIÓN CON LA INFORMACIÓN DE

SALUD Acceso. Tiene derecho a consultar u obtener copias de su información de salud, con excepciones limitadas. Debe presentar una solicitud por escrito. Puede obtener un formulario para solicitar acceso utilizando la información de contacto que figura al final de este aviso. También puede enviar una carta al domicilio que se encuentra al final de este aviso para solicitar el acceso. Si solicita información que conservamos en papel, podemos proporcionarle fotocopias. Si solicita información que mantenemos en formato electrónico, tiene derecho a recibir una copia electrónica. Utilizaremos el formulario y el formato que usted solicite si está disponible. Le cobraremos una tarifa razonable basada en el costo de los suministros y la mano de obra de la copia, y por el franqueo si desea que le envíen copias por correo. Utilice la información que se encuentra al final de este aviso para comunicarse con nosotros y solicitar una explicación de nuestra estructura de tarifas.

Si se le deniega una solicitud de acceso, tiene derecho a que se revise la denegación de acuerdo con los requisitos de la ley vigente.

Listado de la información divulgada. Con excepción de ciertas divulgaciones, tiene derecho a recibir un listado de las divulgaciones de su información de salud conforme a las leyes y regulaciones vigentes. Para solicitar un listado de las divulgaciones de su información de salud, debe enviar la solicitud por escrito al funcionario encargado de la privacidad. Si solicita este listado más de una vez en un periodo de 12 meses, Podemos cobrarle una tarifa razonable basada en el costo por responder a las solicitudes adicionales.

Derecho a solicitar una restricción. Tiene el derecho de solicitar restricciones adicionales al uso o divulgación que nosotros hacemos de su PHI, enviando una solicitud por escrito al funcionario encargado de la privacidad. Su solicitud por escrito debe incluir: (1) qué información desea limitar; (2) si desea limitar nuestro uso, divulgación o ambos; y (3) a quién desea aplicar los límites. No estamos obligados a aceptar su solicitud salvo en el caso en que la divulgación se realice a un plan de salud para efectuar un pago o llevar a cabo actividades de atención médica, y la información se relaciona exclusivamente con un artículo o servicio de atención médica por el cual usted, o una persona en su nombre (que no sea el plan de salud), haya pagado íntegramente en nuestro consultorio.

Comunicación alternativa. Tiene el derecho a solicitar que nos comuniquemos con usted en relación con su información de salud a través de medios alternativos o en lugares alternativos. Debe solicitarlo por escrito. Su solicitud debe especificar los medios o lugares alternativos, y brindar una explicación satisfactoria de cómo se manejarán los pagos conforme a los medios o lugares alternativos que usted solicite. Admitiremos todas las solicitudes razonables. Sin embargo, si no podemos comunicarnos con usted a través de los medios o lugares que ha indicado, podemos usar la información que tenemos para contactarlo.

Enmienda. Tiene el derecho de solicitar que enmendemos su información de salud. Su solicitud debe ser por escrito, y debe explicar por qué se debe modificar la información. Podemos rechazar su solicitud en ciertas circunstancias. Si aceptamos su solicitud, modificaremos sus registros y se lo notificaremos. Si rechazamos su solicitud de enmienda, le daremos una explicación por escrito de por qué la rechazamos y le explicaremos sus derechos.

Derecho a recibir una notificación sobre un acceso no autorizado. Recibirá notificaciones sobre los accesos no autorizados a su información de salud protegida no asegurada según lo exija la ley.

Aviso electrónico. Puede recibir una copia impresa de este aviso si la solicita, incluso si aceptó recibir este aviso en formato electrónico en nuestro sitio web o por correo electrónico.

PREGUNTAS Y QUEJAS

Si desea más información sobre nuestras prácticas de privacidad o tiene preguntas o inquietudes, comuníquese con nosotros. Si le preocupa que hayamos violado sus derechos de privacidad, o si no está de acuerdo con una decisión que tomamos sobre el acceso a su información de salud o en respuesta a una solicitud que usted hizo para enmendar o restringir el uso o la divulgación de su información de salud, o para que nos comuniquemos con usted a través de medios o lugares alternativos, puede enviarnos una queja utilizando la información de contacto que se encuentra al final de este aviso. También puede presentar una queja por escrito al Departamento de Salud y Servicios Humanos de los Estados Unidos. Le proporcionaremos el domicilio para presentar una queja ante el Departamento de Salud y Servicios Humanos de los Estados Unidos si la solicita. Respaldamos su derecho a la privacidad de su información de salud. No tomaremos represalias de ningún tipo si decide presentar una queja ante nosotros o el Departamento de Salud y Servicios Humanos de los Estados Unidos.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of
Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

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

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

Karen Ho, DDS, Inc
1930 S. Bascom Ave., Suite 220, Campbell, CA 95008
408-558-9444 info@drkarenho.com

PATIENT PHOTO CONSENT FORM

I give permission to Dr. Karen Ho to take photos as part of my dental records. These photos taken may be used for case presentations, to obtain payment from insurance companies as well as case review within our office and/or your referring dentist.

Signature _____ Date _____

Karen Ho, DDS, Inc
1930 S. Bascom Ave., Suite 220, Campbell, CA 95008
408-558-9444 info@drkarenho.com

Broken Appointment Policy

We reserve the right to charge for appointments that are cancelled or broken without 48 hours notice.

Our office policy is to charge \$50.00 per thirty minutes of scheduled time.

Any broken appointment charges will need to be taken care of before you will be able to reschedule for another appointment.

We understand that emergencies arise unexpectedly, and we will carefully assess each instance before applying any broken appointment fees.

We are closed on Fridays. If you have a Monday appointment we would need to hear about any cancellations by the previous Wednesday.

I, the undersigned, have read and understand the broken appointment policy. I agree to pay any fees that are charged, should I fail to keep an appointment.

Signature _____

Date _____