ROBERT R. ZIAJA, D.D.S., M.S.

Board Certified Specialist in Orthodontics

Orthodontics and Dentofacial Orthopedics
for Children, Adolescents, and Adults

48878 Hayes Road
Macomb, MI 48044
(586) 247-6453

22 South Main Street
Clarkston, MI 48346
(586) 247-6453

Welcome to our orthodontic office! We are pleased you have chosen our office for an orthodontic evaluation. We look forward to meeting you.

Your first appointment is an INITIAL EXAMINATION. During this visit, Dr. Ziaja will review the health history and perform a detailed facial growth and orthodontic evaluation to determine if any orthodontic needs are present. Dr. Ziaja will discuss his findings, the necessary treatment, and the most appropriate timing for treatment. The proper time to begin treatment depends on the severity of the problem. Some people should be treated at a young age to intercept problems before they develop or become more difficult to correct. Others can wait until adolescence or adulthood. Dr. Ziaja has the proper training and experience to determine the best age for treatment with the least amount of time and expense. If it is determined this is not the best time to start treatment, we will then begin the OBSERVATION process for periodic re-examinations so that growth and development can be monitored until treatment is indicated.

When treatment is recommended, an appointment for DIAGNOSTIC RECORDS (x-rays, molds of the teeth, and photographs) will be made so your treatment needs can be thoroughly evaluated by Dr. Ziaja. The next appointment, the CONSULTATION, will involve a detailed discussion of the orthodontic problem and the proposed treatment. The anticipated length of treatment and financial arrangements (typically a down payment and monthly installments) will also be discussed. This is a very important and educational experience. It is when you learn about and have an opportunity to provide valuable input regarding the final plan of treatment.

You will find the Initial Examination will be very thorough. Our experience shows that knowledgeable people make informed decisions and become our best patients with the most rewarding results. So that Dr. Ziaja may spend extra time discussing his findings, **please fill out the "Medical and Dental Health History", "Get Acquainted" patient registration form and the "HIPPA Form to Complete" documents.** Please fill out these forms in advance and ***bring the completed forms to the office*** on the day of your first appointment or email them to yourmagicsmile@gmail.com prior to your appointment. The forms are in a fillable PDF format, so you can fill them in and save them on your device. They cannot be saved on the website nor be submitted through the website.

For background information on Dr. Ziaja and our office, please review the "Dr. Ziaja Profile" from Crittenton Hospital and our brochure - "Create the Magic of Your Smile for LIFE".

Every effort will be made to make our office worthy of your trust and to provide you with high quality, personal care in a comfortable atmosphere. Our office uses an open and informative approach toward treatment. We encourage you to feel comfortable to discuss any aspect of the treatment at any time. We take time to educate you, answer your questions, and keep you informed of Catherine's progress throughout treatment. We look forward to the opportunity to serve you and provide orthodontic care to you and your entire family.

We look forward to seeing you. If you have any questions, please feel free to contact our office.

Sincerely,
Robert R. Ziaja, D.D.S., M.S. and staff

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MEDICAL AND DENTAL HISTORY

Name: ____ Birth Date: _____________ Age: _______ Sex: ☐ M ☐ F

1. Are you in good health? ☐ Yes ☐ No

2. Has there been any change in your general health in the last year? ☐ Yes ☐ No

3. Have you been examined by your physician within the last year? ☐ Yes ☐ No

   Date of the last exam ____

4. Are you being treated for any condition by a physician now? ☐ Yes ☐ No
   If so, for what? ____

5. Have you ever had surgery or x-ray treatment for a tumor, growth, or other condition? ☐ Yes ☐ No

6. Have you ever been seriously ill, hospitalized, or had a major operation? ☐ Yes ☐ No
   ____

7. Have you ever had, been diagnosed as having, or ever been treated for any of the following:

a)	Alcohol or drug use or dependency	☐ Yes	☐ No	n)	Diabetes (sugar diseases)	☐ Yes	☐ No
b)	Allergies or asthma	☐ Yes	☐ No	o)	Emotional or psychological disorders	☐ Yes	☐ No
c)	Anemia	☐ Yes	☐ No	p)	Endocrine, hormone, thyroid disorders	☐ Yes	☐ No
d)	Arthritis or rheumatism	☐ Yes	☐ No	q)	Epilepsy, seizures, or convulsions	☐ Yes	☐ No
e)	Blood disorders or diseases	☐ Yes	☐ No	r)	Fainting or dizziness	☐ Yes	☐ No
f)	Blood transfusion	☐ Yes	☐ No	s)	Frequent vomiting	☐ Yes	☐ No
g)	Bone disorders or diseases	☐ Yes	☐ No	t)	Hearing disorder or problem	☐ Yes	☐ No
h)	Breathing, nasal, or sinus problems	☐ Yes	☐ No	u)	Heart murmur	☐ Yes	☐ No
i)	Cancer	☐ Yes	☐ No	v)	Heart problems or heart attack	☐ Yes	☐ No
j)	Canker sores	☐ Yes	☐ No	w)	Herpes	☐ Yes	☐ No
k)	Chest pain, pressure, or tightness	☐ Yes	☐ No	x)	High blood pressure	☐ Yes	☐ No
l)	Cold sores	☐ Yes	☐ No	y)	Hives or skin rash	☐ Yes	☐ No
m)	Congenital deformities (birth defects)	☐ Yes	☐ No	z)	Jaundice (yellow skin or eyes)	☐ Yes	☐ No

8. Have you ever had, been diagnosed as having, or ever been treated for any of the following:

a)	Kidney diseases or disorders	☐ Yes	☐ No	k)	Rheumatic heart disease	☐ Yes	☐ No
b)	Learning disability or slow learner	☐ Yes	☐ No	l)	Shortness of breath	☐ Yes	☐ No
c)	Liver disorders	☐ Yes	☐ No	m)	Speech problems or speech therapy	☐ Yes	☐ No
d)	Low blood pressure	☐ Yes	☐ No	n)	Stomach ulcers	☐ Yes	☐ No
e)	Lung (respiratory) problems	☐ Yes	☐ No	o)	Stroke	☐ Yes	☐ No
f)	Nervous disorders	☐ Yes	☐ No	p)	Swallowing difficulties	☐ Yes	☐ No
g)	Painful or swollen joints	☐ Yes	☐ No	q)	Swelling in ankles or feet	☐ Yes	☐ No
h)	Persistent cough or coughing up blood	☐ Yes	☐ No	r)	Tonsils/adenoids removed	☐ Yes	☐ No
i)	Prolonged bleeding	☐ Yes	☐ No	s)	Tuberculosis (TB)	☐ Yes	☐ No
j)	Rheumatic fever	☐ Yes	☐ No	t)	Venereal diseases (VD)	☐ Yes	☐ No

u) Any disease, condition, disorder, or problem not listed in numbers 7 and 8 above? ☐ Yes ☐ No

   If so, describe ____

9. Have you ever had, been exposed to, or are a carrier of:
   a) Acquired Immune Deficiency Syndrome (AIDS) ☐ Yes ☐ No
   b) Hepatitis ☐ Yes ☐ No

10. Are you taking any of the following medications:

a) Antibiotics or sulfa drugs	☐ Yes ☐ No	g) Dilantin or other anticonvulsant	☐ Yes ☐ No
b) Anticoagulants (blood thinners)	☐ Yes ☐ No	h) High blood pressure medications	☐ Yes ☐ No
c) Aspirin, Tylenol, or Motrin (ibuprofen)	☐ Yes ☐ No	i) Insulin, Tolbutamide or Orinase etc.	☐ Yes ☐ No
d) Birth control pills	☐ Yes ☐ No	j) Nitroglycerine	☐ Yes ☐ No
e) Cortisone, steroids, or hormones	☐ Yes ☐ No	k) Ritalin	☐ Yes ☐ No
f) Digitalis, or other drugs for heart trouble	☐ Yes ☐ No	l) Tranquilizers	☐ Yes ☐ No
		m) Any other medications or drugs?	☐ Yes ☐ No

If so, please list ____

11. Have you ever experienced a bad reaction to any of the following drugs:

a) Aspirin, Tylenol, or Motrin (ibuprofen)	☐ Yes ☐ No	e) Iodine	☐ Yes ☐ No
b) Barbiturates	☐ Yes ☐ No	f) Penicillin or other antibiotics	☐ Yes ☐ No
c) Codeine	☐ Yes ☐ No	g) Sedatives or sleeping pills	☐ Yes ☐ No
d) Dental or general anesthetics	☐ Yes ☐ No	h) Sulfonamides (sulfa drugs)	☐ Yes ☐ No
		i) Any other medications or drugs?	☐ Yes ☐ No

If so, please list ____

12. Have you lost weight without dieting in recent months? ☐ Yes ☐ No

13. Do you get short of breath when you lie down or do you require extra pillows to sleep? ☐ Yes ☐ No

14. Do you urinate (pass water) more than eight times a day? ☐ Yes ☐ No

15. Are you thirsty much of the time? ☐ Yes ☐ No

16. Have you had abnormal bleeding associated with previous surgery, extractions, or accidents? ☐ Yes ☐ No

17. Do you bleed for a long time when you cut yourself or spontaneously bruise? ☐ Yes ☐ No

18. Do you tend to be nervous, tense, or high strung? ☐ Yes ☐ No

19. Do you get tired easily? ☐ Yes ☐ No

20. Females: Are you pregnant or trying to get pregnant at this time? ☐ Yes ☐ No

21. Females: Do you have any problems with your menstrual periods? ☐ Yes ☐ No

GROWTH AND DEVELOPMENT INFORMATION (for children and adolescent patients)

22. Patient's height ____ft _____in and weight ______lbs; Father's height ____ft _____in; Mother's height ____ft _____in

23. The patient's general development resembles their: ☐ Father's ☐ Mother's ☐ Neither

24. Has the patient reached puberty (menstruation, facial hair, voice change)? ☐ Yes ☐ No

    If so, at what age _____years, ______months

25. Is the patient currently undergoing a growth "spurt"? ☐ Yes ☐ No

    If so, how many inches have they grown in the last 6 months ______ inches

DENTAL HISTORY

26. Have you ever had any serious problems associated with previous dental treatment? ☐ Yes ☐ No

27. Have you had a dental exam within the last year? ☐ Yes ☐ No

28. Have you ever had orthodontics (braces), retainer, or any treatment to move teeth or change growth? ☐ Yes ☐ No

29. Have you ever had teeth extracted? ☐ Yes ☐ No
If so, which ones and at what age? ____

30. Have you ever been informed of any missing or extra permanent teeth? ☐ Yes ☐ No
If so, which ones? ____

31. Do you have sensitive teeth? ☐ Yes ☐ No
If so, where and to what (biting, hot, or cold, etc.) ____________________________________

32. Do you have any difficulty breathing through your nose while awake or asleep? (circle appropriate one) ☐ Yes ☐ No
If so, do you snore while sleeping? ☐ Yes ☐ No

33. Do you breathe through your mouth, while asleep or awake? (circle appropriate one) ☐ Yes ☐ No

34. Have you ever had a habit of sucking/biting your thumb, finger, lip or other objects? ☐ Yes ☐ No
If so, is it still present? ☐ Yes ☐ No At what age did it stop? ___________

35. Do your gums bleed when you brush your teeth? ☐ Yes ☐ No

36. Have you ever been treated for periodontal or gum disease (pyorrhea)? ☐ Yes ☐ No

37. Do you currently have any sores or swellings in your mouth? ☐ Yes ☐ No

38. Do you have sinus congestion? ☐ Yes ☐ No

39. Do you have difficulty in chewing foods? ☐ Yes ☐ No

40. Have you ever woken up with tight or sore jaw muscles? ☐ Yes ☐ No

41. Do you or have you been told that you grind or clench your teeth, while awake or asleep? ☐ Yes ☐ No

42. Is it difficult for you to open your mouth as wide as you would like? ☐ Yes ☐ No

43. Do you have any pain or soreness in or around your eyes? ☐ Yes ☐ No

44. Have you ever been in an automobile accident or had an injury / blow to the face, head, jaws, teeth, or neck including those you may consider minor? ☐ Yes ☐ No
If so, when and describe ____

45. Have you ever had ear, neck, jaw, or jaw joint (around ear) pain or soreness? ☐ Yes ☐ No
If so, describe ____

46. Have you ever had facial pain (including headaches and muscle pain)? ☐ Yes ☐ No
If so, describe ____
Are they? ☐ Constant ☐ Intermittent ☐ Frequent ☐ Last for long periods

47. Has your jaw ever made a clicking, grinding, or other sound when opening/closing, chewing, or yawning? ☐ Yes ☐ No
If so, on which side? ☐ Right ☐ Left ☐ Both Was it painful? ☐ Yes ☐ No

48. Has your jaw ever locked open or closed? ☐ Yes ☐ No
If so, on which side? ☐ Right ☐ Left ☐ Both Was it painful? ☐ Yes ☐ No

....

The undersigned agrees that the information provided is complete and accurate. I agree to immediately inform this office of any change(s) in the above patient's medical and dental health status or history.

____ Today's Date _________________
Signature of patient (and parent, if the patient is a minor).

PLEASE RETURN COMPLETED HISTORY AT YOUR EXAMINATION APPOINTMENT

ORTHODONTICS by Ziaja
Robert R. Ziaja, D.D.S., M.S., Specialist in Orthodontics

PATIENT ACKNOWLEDGMENT AND CONSENT FORM

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: (1) A defense to a claim challenging our professional competence; (2) A review entity's functions; (3) A claim for payment of fees; (4) A third party payer's examination of our records; (5) A court order as part of a criminal investigation; (6) An identification of a dead body; (7) A licensure investigation; or (8) A child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

PLEASE SIGN THIS FORM BELOW UNDER THE HEADING "ACKNOWLEDGMENT" TO ACKNOWLEDGE THAT YOU HAVE TODAY RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

PATIENT ACKNOWLEDGMENT - for Patient's 18 years or older

IF THE PATIENT IS 18 YEARS OLD OR OLDER, I acknowledge that I, have today received a copy of the Notice of Privacy Practices.

____________________________ ____________________________ _______________

Signature of Patient | Patient Name (please print) | Date

For office use only

- ☐ Patient Refused to Sign
- ☐ The following circumstances prohibited the patient from signing the Acknowledgment: ____
- ☐ An emergency situation prevented the patient from signing the Acknowledgement.

____________________________ ____________________________ _______________

Office Personnel (signature) | Office Personnel (print name) | Date

PLEASE SIGN THIS FORM BELOW UNDER THE HEADING "CONSENT" TO CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.

PATIENT CONSENT - for Patient's 18 years or older

I, consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

____________________________ ____________________________ _______________

Patient Signature | Patient Name (please print) | Date

ROBERT R. ZIAJA, D.D.S., M.S.

GET ACQUAINTED - ***General and Insurance Information (A)***

PLEASE PRINT CLEARLY

PART I

PATIENT NAME ______________________________ NICKNAME(if used) ___________ DATE OF BIRTH _____________ AGE ______ SEX ☐ M ☐ F

HOME ADDRESS ____ CITY __________________________ STATE ________ ZIP CODE.__________________

SOCIAL SECURITY NO. __________________________ DRIVERS LICENSE NO. _____________________________ HOME PHONE NO._________________

EMPLOYER ____ OCCUPATION __________________________ CELL PHONE NO___________________

BUSINESS ADDRESS ______________________________________ CITY _____________________ STATE ______ WORK PHONE NO ___________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DECEASED ☐ SEPARATED ☐ DIVORCED ☐ REMARRIED

If Patient is covered by their own insurance, finish completing PART I. If coverage is from a spouse, continue to PART III.

DENTAL INSURANCE CO.__________________________________ ADDRESS ____________________________ GROUP NO _________________________

MEDICAL INSURANCE CO._________________________________ ADDRESS ____________________________ GROUP NO _________________________

PLAN CODE ____ COVERAGE CODE ____

PART II

PERSON NOT LIVING WITH YOU TO CONTACT IN EMERGENCY ______________________________ PHONE _______________ RELATION _______________

PHYSICIAN ________________________ ADDRESS _______________________________ CITY _______________________ PHONE _____________________

DENTIST ________________________ ADDRESS _______________________________ CITY _______________________ PHONE _____________________

WHOM MAY WE THANK FOR REFERRING YOU ____

PATIENT'S HOBBIES, INTERESTS, ACTIVITIES ____

NAMES AND AGES OF OTHER SIBLINGS ____

HAVE OTHER SIBLINGS/PARENTS HAD ORTHODONTICS OR HAD SIMILAR ORTHODONTIC PROBLEMS?____

HAVE YOU SEEN ANOTHER ORTHODONTIST? ☐ YES ☐ NO DATE ____

PART III

SPOUSES FULL NAME ____ DATE OF BIRTH __________________________

HOME ADDRESS ____ CITY __________________________ STATE ________ ZIP CODE.__________________

SOCIAL SECURITY NO. __________________________ DRIVERS LICENSE NO. _____________________________ HOME PHONE NO._________________

EMPLOYER ____ OCCUPATION __________________________ CELL PHONE NO___________________

BUSINESS ADDRESS ______________________________________ CITY _____________________ STATE ______ WORK PHONE NO ___________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DECEASED ☐ SEPARATED ☐ DIVORCED ☐ REMARRIED

DENTAL INSURANCE CO.__________________________________ ADDRESS ____________________________ GROUP NO _________________________

MEDICAL INSURANCE CO._________________________________ ADDRESS ____________________________ GROUP NO _________________________

PLAN CODE ____ COVERAGE CODE ____

PART IV

PERSON RESPONSIBLE FOR FINANCIAL OBLIGATION _____________________________________ DATE OF BIRTH __________________________

If information requested below is different from PARTS I or III, then please finish completing PART IV.

HOME ADDRESS ____ CITY __________________________ STATE ________ ZIP CODE_________________

SOCIAL SECURITY NO. __________________________ DRIVERS LICENSE NO. _____________________________ HOME PHONE NO._________________

EMPLOYER ____ OCCUPATION __________________________ CELL PHONE NO___________________

BUSINESS ADDRESS ______________________________________ CITY _____________________ STATE ______ WORK PHONE NO ___________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DECEASED ☐ SEPARATED ☐ DIVORCED ☐ REMARRIED

DENTAL INSURANCE CO.__________________________________ ADDRESS ____________________________ GROUP NO ________________________

MEDICAL INSURANCE CO._________________________________ ADDRESS ____________________________ GROUP NO _________________________

PLAN CODE ____ COVERAGE CODE ____

SIGNATURE OF RESPONSIBLE PARTY ____ DATE ____________________________

ORTHODONTICS by Ziaja
Robert R. Ziaja, D.D.S., M.S., Specialist in Orthodontics

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 April14, 2003 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. This transmission can be by mail and/or unsecured email.

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.

Michigan dental patient consent law: We are required by Michigan law to obtain your written consent prior to making certain disclosures of your health information.

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, Office Sign-in Screens, Waiting Room Postings/Bulletin Boards: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters). We may use or disclose your name, health information and picture in our waiting room and/or website for (1) your appointment sign-in acknowledging that you have arrived for your appointment, (2) our posted “Welcome to our Office” list, (3) our posted Congratulations on your “Deband or Appliance Removal” list, (4) Postings of pictures, newspapers articles, or “Patient Clubs” which may mark certain milestones in your treatment and/or special events, (5) office newsletters, or (6) our website which may include before and after pictures.

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, it is customary that we will charge you for each page copied and a duplication fee for each radiograph, set of models, and photograph copied, as well as, an hourly fee for the staff time to locate and copy your health information. If you want the copies mailed to you, postage costs will also be applied. 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, cost-based 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 the 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 the 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 mail (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 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.

Contact Officer: Office Manager **Telephone:** 586-247-6453 **Address:** 48878 Hayes, Macomb, MI 48044

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