Jack D. Steele, D.M.D. , L.L.C.

Medical/Dental History

The following information is essential for us to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to safely and efficiently protect your dental healthcare needs. Incorrect information can be dangerous to your health. If you have any questions we will be happy to assist you.

Patient Name (First) _____ (MI) ___ (Last) _____ Preferred Name_____ Birth Date___/___/___SS #_____

Mailing Address: (P.O. Box/Street address) _____ (City, State, Zip) _____

Telephone # _____ Cell Phone#_____ Alternate #_____ Work #_____

Employer Name_____ Address: _____ Employer Phone # _____

Telephone#_____ Does your employer provide dental insurance? Y/N Are any immediate family members patients? Y/N

Spouse/Parent (minor patient) Name (First) _____ (MI) ___ (Last) _____ Birth Date ___/___/___ SS#_____

Mailing Address :(P.O.Box/Streetaddress)_____ (City, State, Zip) _____

Telephone # _____ Cell Phone #_____ Alternate #_____ Work #_____

Employer Name: _____Address:_____ Employer Phone # _____

Telephone #_____ Does your employer provide dental insurance? Y/N Are you a current patient? Y/N

Primary Insurance: Subscriber Name_____ Subscriber ID #_____Group #_____

Insurance Name: _____Address: _____ Phone_____

Secondary Insurance: Subscriber Name _____ Subscriber ID# _____ Group #_____

Insurance Name: _____Address _____Phone _____

Physician Name: _____ Phone # _____Address:_____

Specialist Name: _____ Phone # _____Address:_____

Do we have your permission to contact your physician/specialist concerning any health related issues related to your dental care? Y/N Last visit: _____

Are you currently under the care of a physician? Y/N Explain: _____

Allergies: (circle those that apply) Aspirin Tylenol Ibuprofen Erythromycin Penicillin Tetracycline Latex Codeine Dental Anesthetics Iodine

List any other medication/food/environmental allergies: _____

Medications: Please list all medications you are taking, include over the counter medications, vitamin supplements, herbals and holistic medications. (You may attach a list)Please include dosage information (strength, how many times taken per day/week)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CONTINUED ON BACK

Form Completion Date / /

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING? Check all that apply.

☐ Anemia	☐ Circulatory Problems	☐ High Blood Pressure	☐ Rheumatic fever	☐ Hemophilia
☐ Artificial Heart Valves	☐ Cough Persistent/chronic	☐ HIV Positive	☐ Skin Rash	☐ Cold sores
☐ Artificial Joints	☐ Cough up blood	☐ AIDS	☐ Stroke	☐ Stents/Shunts
☐ Asthma	☐ Diabetes I or II	☐ Kidney Disease	☐ Congestive heart failure	
☐ Autoimmune disease	☐ Epilepsy/seizures	☐ Mitral Valve Prolapse	☐ Heart Disease (describe) _____	
☐ Back Problems	☐ Fainting	☐ Cancer (describe) _____	☐ Thyroid Disease	☐ Herpes
☐ Blood disease	☐ Leukemia	☐ Eye disorder	☐ Nervous disorder	☐ Blood Transfusion
☐ Tobacco Habit	☐ Headaches	☐ Chemical/Alcohol dependency	☐ Tuberculosis (describe) _____	
☐ Abnormal bleeding	☐ Heart Murmur	☐ Psychiatric care	☐ Ulcer/Digestive problems	
☐ Prolonged healing	☐ Radiation Treatment	☐ Chemotherapy	☐ Venereal Disease	☐ Pacemaker
☐ Chemical Dependency	☐ Hepatitis A B C	☐ Liver disease/jaundice	☐ Respiratory Disease	☐ Fen-phens diet med.

Any other health related issues not covered by the above conditions (please describe (pregnancy, disease, etc):

_____

Are you presently taking or have you had **Bisphosphonate Therapy?** Y / N Aredia or Zometa Other?_____

Have you taken or do you take **oral Bisphosphonate?** Y / N **Which medication:** Actonel Boniva Fosamax Skelif Didronel Other:_____

How long have you been receiving bisphosphonate therapy? _____

Dental History

Do you have or have you had any of the following? Check all that apply:		☐ Popping sound when you chew or eat		☐ Abscessed teeth
☐ Third molars (wisdom teeth) removed?	☐ Orthodontics- Orthodontist's name: _____		☐ Missing teeth	☐ Dry Mouth
☐ Full Dentures/Partial Dentures	☐ Blisters or lesions	☐ Pain in jaw joint	☐ Bleeding gums	☐ Loose teeth
☐ Clenching or grinding teeth	☐ Difficulty chewing	☐ Bad Breath	☐ Sensitive teeth	☐ Food Trap

What would you like to change about your smile? _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. X_____

I understand this information will be used by Dr. Steele and staff to help determine appropriate and healthful dental treatment. If there are changes in my medical status I will inform Dr. Steele/staff. At each visit a treatment plan will be presented and the work to be done is explained to me before treatment is begun. I give Dr. Steele and staff my consent to perform any needed dental treatment. (patient's signature (parent/guardian for minor) x_____

I authorize the use of this signature on all insurance submissions and I also authorize Dr. Steele/staff to release all information necessary to secure payment of insurance benefits on my behalf. (patient's signature, parent/guardian for minor patient) X _____

I authorize payment to come directly to the office of Dr. Jack D. Steele, D.M.D. (patient's signature, parent/guardian for minor patient).X _____

I understand I am fully financially responsible for all charges whether covered, not covered, or denied by my insurance company. (patient's signature, parent/guardian for minor patient). X _____

Minor/child consent: I (parent/guardian) x_____ do hereby request and authorize Dr. Jack Steele and staff to perform necessary dental services for my child, including but not limited to X-rays, preventative and restorative procedures, administering local anesthetics and nitrous oxide which are deemed advisable by Dr. Steele, whether I am present or not present at the actual appointment when the treatment is rendered. I also give permission to Dr. Steele and staff to discuss my child's treatment with the person presenting at the appointment with my child. If my minor child arrived alone I consent to the above statements in order for my minor child to receive dental treatment in the office of Dr. jack D. Steele D.M.D. (signature of parent or legal guardian) X _____ * Reason and relationship to alternate signature if person signing is not the patient.

_____

Jack D. Steele, D.M.D., L.L.C.

Emergency Contact Information

In case of an emergency please supply the contact information for persons we may contact, on your behalf, in case of an emergency.

Emergency Contact #1:

Name: _____ Relationship to you: _____

Telephone No: _____ Mobile: _____ Work: _____

Address: _____

Emergency Contact #2:

Name: _____ Relationship to you: _____

Telephone No: _____ Mobile: _____ Work: _____

Address: _____

CONTINUED ON BACK

Jack D. Steele, D.M.D., L.L.C.

Failed or Canceled Appointment Policy

I understand that if I fail to show for a scheduled appointment or cancel an appointment without giving a 24 (twenty four) hour notice there will be a $25.00 (Twenty five dollar) fee assessed to my account which will be due and payable by me within a period of 10 (ten) days of the scheduled appointment date.

Patient Signature (parent or guardian if patient is a minor) Date

****Please note: If a patient cancels without a 24 hour notice, or fails to show for 3 scheduled appointments, that patient will be asked to secure the services of a dentist who can better suit their scheduling needs and will be dismissed from our practice.

******NEW PATIENTS or INACTIVE PATIENTS (NOT SEEN WITHIN THE PAST 2 YEARS) scheduling their first appointment in our office: If you fail to show or cancel without a 24 hour notice your appointment will not be rescheduled

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ____/____/____

Jack D. Steele, D.M.D.
501 E. Poplar St
McConnellsburg, PA 17233

Jack D. Steele, D.M.D. Family Dentistry, L.L.C.

FINANCIAL POLICY ACKNOWLEDGEMENT AND AGREEMENT

- Co-Signature: if another person signs this or another Financial Policy Acknowledgement and Agreement with this office, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges. It does not release them from the responsibility of ***prior*** charges that were incurred.
- Effective Date: Once you have signed this agreement, you agree to all terms and conditions contained in the written Financial Policy and the agreement will be in full force and effect.

1. I hereby state that I have read and understand the Financial Policy given to me by the office of Jack D. Steele, D.M.D, L.L.C.

X_____ X_____

Signature Co-Signature

2. My signature below indicates that I accept financial responsibility for the following individuals who are patients in the practice of Dr. Jack D. Steele, D.M.D, L.L.C. **** Include your name if you are a patient in this practice.***

*_____ _____

_____ _____

_____ _____

3. Signature of Financially Responsible Individual (s)

X_____ X_____ _____

Signature Printed Name Date

X_____ X_____ _____

Co-Signature Printed Name Date

4. Past Due Accounts Submitted to Collection Agency: I agree and fully understand that if my account is delinquent and submitted to a collection agency by the office of Jack D. Steele, D.M.D., L.L.C. the following will apply: I agree to pay the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses including reasonable attorney's fees, which the office of Jack D. Steele, D.M.D., L.L.C., will incur in such collection efforts. In the case of suit in a court of law, I agree the venue shall be in the county in which my dental treatment was delivered. If my account is submitted to an attorney or collection agency, the fact that I, and any dependents or spouse listed on my account, received treatment in the office of Jack D. Steele D.M.D., L.L.C. may become a matter of public record and will result in a "Waiver of Confidentiality".

X_____ X_____ _____

Signature **Printed Name** **Date**

X_____ X_____ _____

Co-Signature **Printed Name** **Date**

Jack D. Steele, D.M.D., Family Dentistry, L.L.C.

Acknowledgment of Receipt of Notice of Privacy Practices

Under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA", I understand that I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct treatment and follow-up among healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers (for example insurance companies)
- Conduct normal healthcare operations.

I have received, read and understand the *Notice of Privacy Practices* document containing a more complete description of the uses and disclosures of my health information. I understand that Jack D Steele, D.M.D., Family Dentistry, L.L.C., has the right to change it's *Notice of privacy practices from time to time and that I may contact this organization at any time at the address below for a current copy of the Notice of Privacy* Practices *Document.*

Do we have your permission to:

- Leave a message on your answering machine and send text messages? Yes No
- Confirm appointments by leaving messages or speaking with family? Yes No
- Speak to household members concerning your treatment and care? Yes No

Patient Name _____ Signature _____ Date _____

Name/relationship to patient _____ Signature _____ Date _____

FOR OFFICE USE ONLY

☐ Practice provided the above-referenced patient with the practice's notice of privacy practices and this acknowledgement of receipt of practices, but could not obtain a signed acknowledgement from the patient/guardian/parent because:

- o Patient or guardian refused to sign:
- o Emergency Situation:
- o Other _____

_____ _____

Received by (Staff signature) Date

Financial Policy

Jack D. Steele, D.M.D., L.L.C.

It is our goal to provide you with the finest quality dental care available at a cost that is both fair and reasonable. In order to achieve this goal, we need your cooperation and your understanding of our payment policy. The following is a statement of our Financial Policy which we require you to read and sign. Our office accepts cash, personal checks (no third party checks), Visa, MasterCard, Discover Card and CareCredit for your convenience. It is your responsibility to provide accurate and current contact information (address/phone) and insurance coverage information. Failure to do so is a conflict of this financial agreement.

- **Self-Pay:** Payment is due in full at the time services are rendered. IF you have no traditional dental insurance you are considered self-pay.
- **Reimbursement Insurances:** Reimbursement insurances pay you, the patient, directly and are considered as **Self Pay** accounts (see above) as a courtesy we will submit your claim to your insurance carrier on your behalf.
- **Traditional Dental Insurance:** Your dental insurance is a contract between **you and your insurance carrier**. As a courtesy to your patients we agree to file your insurance claims, however we **DO NOT** assume responsibility to know the full benefits of your individual plan. We recommend that you question your insurance company regarding your benefits and limitations of your coverage. Do not assume that all treatment received in the dental office is covered by your plan. Of office is unable to file claims for patients who do not provide us with current, accurate insurance information. In the event you are unable to provide us with your confirmable insurance information (ID and group numbers, mailing address) your account will be treated as SELF PAY (see self-pay above). It is your responsibility to provide us with your current insurance information. Please inform us immediately of any changes in coverage. Charges not paid by your insurance company within 90 days of claim submission will become due and payable by you.
- **Participating Provider:** WE participate with MOST Delta Dental, United Concordia, United Concordia GRID, Cigna, and Blue Cross Dental insurance plans. ***Although we participate with these plans you will have a co pay, deductible or co-insurance due this office.*** Collection of these deductibles and co pays is an insurance requirement for which we are under contract to bill and collect these fees, they cannot be waived. Failure to pay these charges may result in reposting of the contractual deduction to your account as permitted by our contract with your insurance company.
- **Predetermined Benefits:** Predetermination of benefits is ***NOT*** a guarantee of payment by your insurance company. If the submitted predetermined claim is denied by your insurance company or an adjustment in benefits is conveyed, you will be held responsible for payment of the service (s).
- **Denied Services:** In the event your insurance company determines a service to be "***Not Covered***, you will be held responsible for payment. *It is your responsibility to understand your insurance benefits and limitations.*
- **Medical Access:** In order for us to accept and file PA Medical ACCESS (Plus) and the other insurance administrators of the PA Medicaid Programs, you must present your current valid insurance card at each visit; any co pay is due at the time of service. Co pays for this insurance are assessed on patients 18 years of age or older and due on the date of service unless you have been rendered "Unable to Pay" by the PA. Dept. of Public Welfare and have supplied our office with the proper documentation.
- **Divorce:** The responsibility for payment of services rendered to dependent children with divorced/separated parents rests with the ***Presenting Parent*** (Parent seeking treatment for dependent children). If there is a court ordered responsibility of judgment decree that requires the other parent to pay part or all of the treatment

costs, it is the authorizing (presenting) parent's responsibility to collect payment from the other parent. It is also the authorizing (presenting) parent's responsibility to provide us with any insurance information that we may require to file an insurance claim on the dependents behalf.

- **Monthly Statement:** If there is a balance due on your account this office will issue a statement which will indicate the balance due as of that date. The balance is due ***"In Full"*** by the due date listed on the statement. If payment is not received in this office within 30 days it is considered delinquent. An Administrative Rebilling Fee (currently $5) will be added to any subsequent statements issued by this office on unpaid balances which is due and payable to this office. We reserve the right to dismiss you, and/or your family members listed on your account, from the practice if your account is not maintained in a fair equitable manner.
- **Past Due Accounts:** If your balance becomes past due or delinquent, we will take the necessary steps to collect this debt. If your account is referred to a collection agency, you agree to pay us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorney's fees, which we incur in such collection efforts. In case of suit in a court of law you agree the venue shall be in the county in which your dental treatment was delivered. If your account is submitted to an attorney or collection agency, the fact that you received treatment in our office may become a matter of public record and will result in a ***Waiver of Confidentiality".***
- **Missed Appointment Fee:** Our office reserves the right to charge a fee for missed or canceled appointments. If a patient fails to show, does not arrive on time, or does not cancel 24 hours prior to the scheduled time a fee of $25 **per scheduled patient** will be charged based on the patient's scheduling history. If after 3 instances of failure to show or failure to cancel within 24 hours of your appointment this office reserves the right to sever our Doctor/Patient relationship and dismiss you from our practice.
- **Returned Check Fee:** A fee of $35 will be charged for checks returned from the bank for ANY reason. We reserve the right to submit your information to the legal authorities if a check is written on a closed account, a forged check or a check written without sufficient funds as these are considered crimes in the state of Pennsylvania. If we received a returned check on your account any and all future services are payable by credit card or cash.
- **After Hours Call:** Dr. Steele will be available for "after hour emergency call" for "Current patients of record only". In the event Dr. Steele is unavailable an alternate dentist will be on call for this office and fees will be charged from the attending dentist's office. An "After Hour Call Fee" will be charged for this service

Jack D. Steele, D.M.D., L.L.C.
Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected health information, 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 08/01/2013, and will remain in effect until we replace it.

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

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

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

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

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and

coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain

electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

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

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

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

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

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

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

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

Questions and Complaints

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

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

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Marcia M. Atherton

Telephone: 717-485-3015 Fax: 717-485-3096

Address: 501 E. Poplar St. McConnellsburg, PA 17233

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