Kenneth W. Leopold, DDS, MS
Practice Limited to Orofacial Pain, Oral Medicine and Sleep Apnea

SYNERGY
TMJ & SLEEP SOLUTIONS

Health History Form

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:
Last *First* *Middle*

Home Phone: *include area code*
( )

Business/Cell: *include area code*
( )

Address: City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M ☐ F ☐

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *include area code* Cell Phone: *include area code*

If you are completing this form for another person, what is your relationship to that person?
Your Name: *Relationship:*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough hat produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Chief Complaint(s):

Describe what you think the problem is: _____

What do you think caused the problem? _____

Describe, in order (first to last), what you expect from your treatment: _____

_____

Dental Information *Please mark (✔) for your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? (Check one) Daily ☐ Weekly ☐ Occationally ☐

	Yes	No	DK
Are you currently experiencing dental pain or discomfort?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Date of your last dental exam:	☐	☐	☐

What was done at that time? _____

Date of last dental x-rays: _____

How do you feel about your smile? _____

TMJ Syndrome and Myofascial Pain Health History *Please mark (✔) for your responses to the following questions.*

Are you presently under the care of a physician or have you been in the past year? ☐ Yes ☐ No

Physician's name: _____

Condition(s) treated: _____

Treatment

Name of medication(s) you are currently taking: _____

_____

_____

How would you describe your overall physical health?

☐ Poor ☐ Average ☐ Excellent

How would you describe your dental health?

☐ Poor ☐ Average ☐ Excellent

Dentist's name: _____

Date of last appointment: _____

Have you had any major dental treatment in the last two years? ☐ Yes ☐ No

If yes, please mark procedure(s):

☐ Orthodontics ☐ Periodontics ☐ Oral Surgery ☐ Restorative

Date(s) of Third Molar (wisdom tooth) extraction(s): _____

History of injury and trauma

Is there any childhood history of falls, accidents of injury to the head or face? ☐ Yes ☐ No

Describe: _____

Is there any recent history of trauma to the head or face? (Auto accident, sports injury, facial impact) ☐ Yes ☐ No

Describe: _____

Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming, instrument) ☐ Yes ☐ No

Describe: _____

Facial Pain Past Treatment

Have you ever been examined for a TMJ problem before? ☐ Yes ☐ No

If yes, by whom? _____ When? _____

What was the nature of the problem? (Pain, noise, limitation of movement):

_____

What was the duration of the problem? _____ Months _____ Years

Is this a new problem? ☐ Yes ☐ No

Is the problem getting ☐ better ☐ worse ☐ staying the same

Have you ever had physical therapy for TMJ? ☐ Yes ☐ No

If yes, by whom? _____ When? _____

Have you ever received treatment for jaw problems? ☐ Yes ☐ No

If yes, by whom? _____ When? _____

What was the treatment? (Please mark below)

☐ Bite Splint ☐ Medication ☐ Physical Therapy

☐ Occulusal Adjustment ☐ Orthodontics ☐ Couseling

☐ Surgery

☐ Other (Please explain) _____

Have you ever had injections for your TMJ with muscle relaxants (BOTOX, Flexeril) cortisone or anti-inflammatories? ☐ Yes ☐ No

If yes, were they effective? ☐ Yes ☐ No

Current Medications/Appliances/Treatments Being Used

No Pain **Moderate Pain** **Severe Pain**

Degree of current TMJ pain: 0 1 2 3 4 5 6 7 8 9 10

Frequency of TMJ pain: ☐ Daily ☐ Weekly ☐ Monthly ☐ Semi-Annually ☐ After Eating

Is the pain ☐ Constant ☐ Continuous ☐ Intermittent?

How long does it last? _____

What is the quality of the pain? Sharp, dull, burning, aching, electrical, etc.

_____

What makes it worse? _____

What makes it better? _____

How often does the pain occur? _____

Does the pain occur on its own or do you need to trigger with function, touching, etc.? _____

If you were to place a Q-tip in your left ear and push forward, does that trigger pain? ☐ Yes ☐ No

Can the pain be triggered by touching the skin with a light brush stroke with a Q-tip or pressing on an area with a Q-tip? ☐ Yes ☐ No

Are you taking medication for TMJ problems? ☐ Yes ☐ No

If yes, what type? _____

How long? _____

Who prescribed the medication? _____

Are the medications that you take effective? ☐ Yes ☐ No

Conditional? ☐ Yes ☐ No

Are you aware of anything that makes your pain worse? ☐ Yes ☐ No

If yes, what? _____

Does your jaw make noise? ☐ Yes ☐ No

If yes, when and how? _____

Right ☐ Clicking/Popping ☐ Grinding ☐ Other _____

Left ☐ Clicking/Popping ☐ Grinding ☐ Other _____

Does your jaw lock open? ☐ Yes ☐ No

If yes, when did this first occur? _____

How often? _____

Has your jaw ever locked closed or partly closed? ☐ Yes ☐ No

If yes, when did this first occur? _____

How often? _____

Have any dental appliances been prescribed? ☐ Yes ☐ No

If yes, by whom? _____

When? _____

Describe: _____

When do you wear your dental appliances? _____

How many dental appliances have you worn? _____

Are these appliances effective? ☐ Yes ☐ No

Is there any additional information that can help us in this area? _____

_____

_____

_____

_____

Current Stress Factors (Please mark each factor that applies to you)

- ☐ Death of a Spouse
- ☐ Divorce
- ☐ Business Adjustment
- ☐ Pregnancy
- ☐ Financial Problems
- ☐ Pending Marriage
- ☐ Fired from Work
- ☐ Career Change
- ☐ Death of a Family Member
- ☐ Taking on Debt
- ☐ Marital Reconciliation
- ☐ New Person Joins Family
- ☐ Major Health Change in Family
- ☐ Major Illness or Injury Marital Seperation

Current and Previous Habits (Please mark your answer to each question)

Do you clench your teeth together under stress?	☐ Yes	☐ No
Do you grind/clench your teeth at night?	☐ Yes	☐ No
Do you sleep with an unusual head position?	☐ Yes	☐ No
Are you aware of any habits or activities that may aggravate this condition?	☐ Yes	☐ No

Describe: _____

Current Symptoms (Please mark each symptom that applies)

Head Pain/Headaches, Facial Pain

Forehead	☐ Lelft	☐ Right
Temples	☐ Left	☐ Right

- ☐ Migraine Type Headaches
- ☐ Cluster Headaches Maxillary Sinus
- ☐ Headaches (under the eyes)
- ☐ Occipital Headaches (back of the head with or without shooting pain)
- ☐ Hair and/or Scalp Painful to Touch

Mouth, Face, Cheek & Chin Problems

- ☐ Discomfort
- ☐ Limited Opening
- ☐ Inability to Open Smoothly

Jaw & Jaw Joint (TMJ) Problems

- ☐ Clicking, Popping Jaw Joints
- ☐ Grating Sounds
- ☐ Jaw Locking Opened or Closed
- ☐ Pain in Cheek Muscles
- ☐ Uncontrollable Jaw/Movements

Eye Pain/Ear Orbital Problems

- ☐ Eye Pain – Above, Below or Behind
- ☐ Bloodshot Eyes
- ☐ Blurring of Vision
- ☐ Bulging Appearance
- ☐ Pressure Behind the Eyes
- ☐ Light Sensitivity
- ☐ Watering of the Eyes
- ☐ Drooping of the Eyelids

Teeth & Gum Problems

- ☐ Clenching, Grinding at Night
- ☐ Tooth Pain
- ☐ Looseness and/or Soreness of Back Teeth

Pain, Ear Problems, Postural Imbalances

- ☐ Hissing, Buzzing or Ringing Sounts
- ☐ Ear Pain without Infection
- ☐ Clogged, Stuffy, Itchy Ears
- ☐ Balance Problems – Vertigo
- ☐ Diminished Hearing

Throat Problems

- ☐ Swallowing Difficulties
- ☐ Tightness of Throat
- ☐ Sore Throat
- ☐ Voice Fluctuations

Neck and Shoulder Pain

- ☐ Arm and Finger Tingling, Numbness, Pain
- ☐ Stiffness
- ☐ Reduced Mobility and Range of Motion
- ☐ Neck Pain
- ☐ Tired, Sore Neck Muscle
- ☐ Shoulder Aches
- ☐ Back Pain, Upper and Lower

Other Pain

_____

_____

_____

Medical Information

Please mark (✔) for your responses to the following questions.

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: _____

Phone: *include area code* _____

Address/City/State/Zip _____

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated? _____

Date of the physical exam: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

Yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medication(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: _____

_____

_____

Do you wear contact lenses?	☐	☐	☐

	Yes	No	DK
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐

Date: _____

If yes, have you had any complications?	☐	☐	☐
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva® Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐

Date Treatment began: _____

Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐

If so, how interested are you in stopping?

☐ Very ☐ Somewhat ☐ Not interested

Do you drink alcoholic beverages?	☐	☐	☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

Medical Information (continued)

	Yes	No	DK
WOMEN ONLY			
Are you pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐
Allergies: Are you allergic to or have you had a reaction to:			
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other _____			
Have you had any of the following diseases or problems?			
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Except for the conditions listed above, antibiotic prophyloxis is no longer recommended for any other form of CHD.			
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damages heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice, or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify _____			
Recurrent infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐
Name of physician or dentist making recommendation:			
Phone: include are code			
Do you have any disease, condition, or problem not listed above that you think I should know about?			
Please explain: _____			

Pain Pattern

You will be asked to fill out this page during your interview/exam with the Dentist.

Draw your pain patterns following this key:

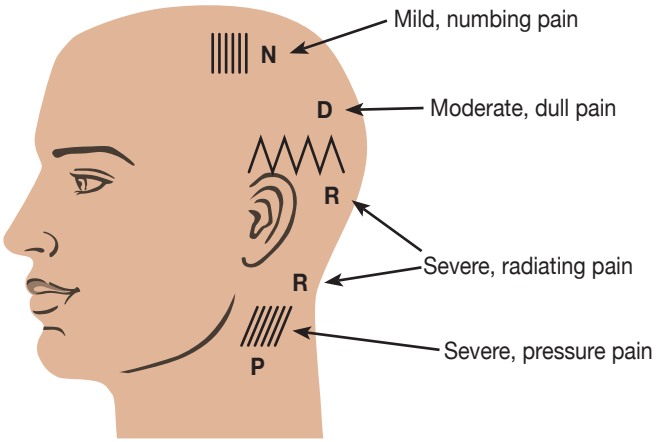
Mild Pain

Moderate Pain

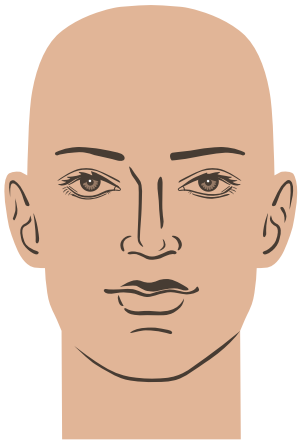
Severe Pain

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating

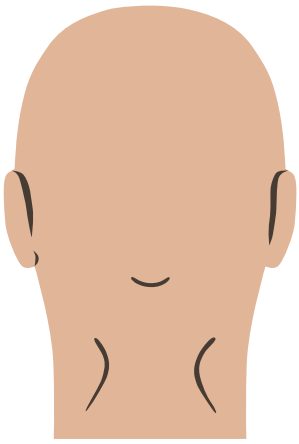
Example



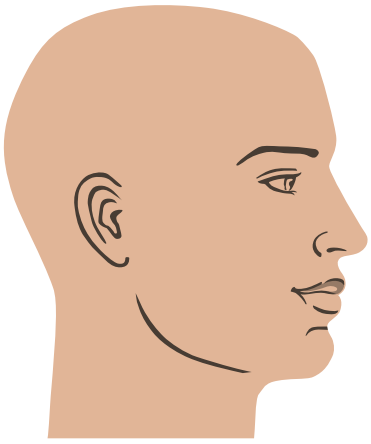
Right **Left**

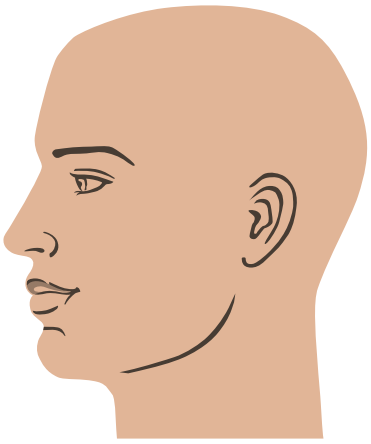


Left **Right**



Right





Left

NOTE: Both doctor or and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

_____

_____

Epworth Sleepiness Scale

Name:_____

Date: _____

Your age (yr): _____

Your sex: ☐ Male ☐ Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

Situation	**Chance of dozing**
Sitting and reading	☐
Watching TV	☐
Sitting, inactive in a public place (e.g. a theatre or meeting)	☐
As a passenger in a car for an hour without a break	☐
Lying down to rest in the afternoon when circumstances permit	☐
Sitting and talking to someone	☐
Sitting quietly after a lunch without alcohol	☐
In a car, while stopped for a few minutes in the traffic	☐
Total	_____

SYNERGY
TMJ & SLEEP SOLUTIONS

Kenneth W. Leopold, DDS, MS
Practice Limited to Orofacial Pain, Oral Medicine and Sleep Apnea

Physician-Patient Arbitration Agreement

Kenneth W. Leopold, DDS, MS

I, _____, have read this agreement in its entirety and understand and agree to the following: **Article 1:** It is understood that any dispute as to medical and/or aesthetic malpractice, that is as to whether any medical and/or aesthetic services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting this use of arbitration. **Article 2: A) Parties to the Agreement:** The tern "Patient" as used in this agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns, or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons and intents to bind each of them to arbitration to the full extent permitted by law. The term "Doctor" as used in the Agreement includes the undersigned Doctor and his or her professional corporation or partnership, all independent contractors who practice medical and/or aesthetic techniques at the undersigned Doctor's place of business, and any employees, agents, successors-in-interest, heirs and assigns of the foregoing individuals or entities. The Doctor signing this Agreement signs it on behalf of all the foregoing individuals and entities, intents to bind each of them to arbitration to the full extent permitted by law. **B)** Treatment covered: Patient understands and agrees that any dispute of the sort described in Article 1 between Doctor and Patient will be subject to compulsory, binding arbitration. **C) Coverage of Prenatal Claims:** (if applicable). Patient understands and agrees that, if Doctor treats her during pregnancy, any dispute of the sort described in Article 1 as to (medical and/or aesthetic) treatment that is claimed to have affected the unborn child will be subject to compulsory, binding arbitration. **Article 3: A) Informal Resolution of Disputes:** In the event the Patient feels that a problem has arisen in connection with the medical and/or aesthetic are rendered by Doctor to Patient, Patient will promptly notify Doctor so that Doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing and shall stop the running of the statute of limitations for ninety (90) days. b) Method of Initiating Arbitration: If the dispute is not resolved by mutual agreement within ten (10) days of the expiration of the ninety (90) days, Patient shall notify Doctor in writing of his or her desire to arbitrate and shall designate an arbitrator. Within twenty (20) days of receipt of such notice, Doctor will designate an arbitrator to act on Doctor's behalf. In the event that two or more parties participate, all plaintiffs agree on one arbitrator, all defendants agree on one arbitrator and those arbitrators select a neutral arbitrator. The controversy shall then be submitted to the three arbitrators for a final and binding decision. The Patient and Doctor agree that all expert witnesses will be from exact specialty and post graduate medical training. **C) Applicable Law:** The arbitration shall be conducted pursuant to the California Arbitration Act (C.C.P. 1280-1295). The arbitrators shall, in addition, have authority to order such other discovery, as they deem appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California including the provisions of the Medical Injury Compensation Reform Act of 1975 which shall apply to the same extents as if the dispute were pending before a superior court of this state. **D) Interpretation of Agreement:** Any controversy concerning the interpretation or application of the Agreement itself, shall also be submitted to arbitration in the manner provided above. **Article 4: Revocation:** If you sign this agreement and then change your mind, the law permits you to revoke the Agreement, providing you give your Doctor written notice within thirty (30) days from signing that you want to withdraw from the Agreement. However, Doctor and Patient agree that any claim arising from medical and/or aesthetic services rendered prior to revocation shall be subject to arbitration. IF notice of revocation of this Agreement is not received within thirty (30) days of its signing, the right to cancel the Agreement is forever waived. **Article 5: Retroactive Effect:** If the signing party intents this Agreement to cover all services rendered before the date of the signing of this Agreement (including, but not limited, prior to consultations or treatment), the signing party must initial here _____. **Article 6: Acknowledgement:** By signing this Agreement, I acknowledge that I have discussed to my satisfaction any questions I may have regarding the arbitration Agreement with a staff member of: **Kenneth W. Leopold, DDS, MS,** and have been given the opportunity to obtain further counsel if desired. I acknowledge that I have freely negotiated all terms herein set forth. Article 7: If any provision of this arbitration Agreement should be held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any provision. **NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL AND/OR AESTHETIC MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY TRIAL OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

_____ **Date:** _____

Patient, Parent, Guardian, or Authorized Representative/if signed by someone other than the Patient, indicate relationship

Notice of Privacy Practices

To our patients: This notice describes how health information about you as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your Health Information in Special Circumstances

1. The following circumstances may require us to use or disclose your health information"
2. To public health authorities and health oversight agencies that are authorized by law to collect information.
3. Lawsuits and similar proceedings in response to a court or administrative order.
4. If required to do so by law enforcement official.
5. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
6. If you are a member of U.S. or foreign military forces (including veterans) and if required by appropriate authorities.
7. To federal officials for the intelligence and national security activities authorized by law.
8. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
9. For workers compensation and similar programs.

Your rights regarding your health information

1. Communication. You can request that our practice communicate with your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical and billing records, but not including psychotherapy notes. You must submit your request in writing.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our office.
5. Right to a copy of this notice. You are entitled to receive a copy of this notice of Privacy Practices. You may ask us to give. You a copy of this notice at any time. To obtain a copy of this notice, contact any front office receptionist at Dr. Leopold's office.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our office. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for used and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our office.

I hereby acknowledge that I have been presented with a copy of Dr. Leopold's Notice of Privacy Practice.

Patient/Guardian Signature: _____Date:_____

Printed Patient Name: _____