VIRUET
Periodontics & Implants

MEDICAL HISTORY FORM

Title _____ First Name _____ Last Name _____ Preferred name _____

Date of Birth _____ Gender Male or Female Are you available for short notice appointments Yes or No

Emergency Contact _____ Telephone number _____ Relationship _____

MEDICAL INFORMATION

Dental professionals primarily treat the area in and around your mouth. Since your mouth is part of your body any medications you are taking as well as your medical history have an important relationship with your dental treatment. Please answer the following questions.

Are you seeing a family physician? If so, please enter name, phone number and date of last visit. _____

_____

Date of last physical exam: _____ Pharmacy Name & Number _____

Have you recently (in the last two years) been hospitalized or had a major operation? Please explain. _____

_____

Have you ever had a serious head, neck, or back injury? If so, please explain. _____

_____

Please, go over the following section and indicate which of the following you have or have had. If you need to add any further information, please enter it at the end.

Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions
☐	☐	Alzheimer's Disease/Dementia	☐	☐	Fibromyalgia	☐	☐	Psychiatric Disorders
☐	☐	Anaphylaxis	☐	☐	Frequent Headaches/Migraines	☐	☐	Radiation Therapy
☐	☐	Anemia	☐	☐	Glaucoma Type: ____	☐	☐	Rheumatoid Arthritis
☐	☐	Anxiety	☐	☐	Head Injuries	☐	☐	Rheumatic Fever
☐	☐	Arthritis/Gout	☐	☐	HIV/AIDS	☐	☐	Respiratory Problems
☐	☐	Aspirin use	☐	☐	Hearing Problems	☐	☐	Sinus Problems
☐	☐	Asthma/COPD	☐	☐	Heartburn	☐	☐	Seizures
☐	☐	Autoimmune diseases	☐	☐	Heart Defects/Repair	☐	☐	Sickle Cell Diseases
☐	☐	Artificial Heart Valve	☐	☐	Heart Attack Date: ____	☐	☐	Stroke/TIA Date:_____
☐	☐	Angina Pectoris	☐	☐	Heart Murmur	☐	☐	Tachycardia
☐	☐	Blood Disorders	☐	☐	Hemophilia	☐	☐	Thyroid Problems
☐	☐	Blood Thinners	☐	☐	Herpes	☐	☐	☐ Hypothyroidism
☐	☐	Blood Transfusions	☐	☐	Hepatitis Type: ____	☐	☐	☐ Hyperthyroidism
☐	☐	Bruise Easily	☐	☐	High Blood Pressure	☐	☐	Tuberculosis
☐	☐	Colitis	☐	☐	High Cholesterol	☐	☐	Tumors
☐	☐	Cancer	☐	☐	Joint replacement	☐	☐	Taken Fen Phen
☐	☐	Chemotherapy	☐	☐	Kidney Problems	☐	☐	Ulcers
☐	☐	Depression	☐	☐	Leukemia	☐	☐	Venereal Diseases
☐	☐	Diabetes ***Last HbA1C:____***	☐	☐	Liver Disease	☐	☐	Use of NSAIDs
☐	☐	Dialysis	☐	☐	Low Blood Pressure	☐	☐	Use of Steroids
☐	☐	Dizziness/Fainting	☐	☐	Nervous Disorders			
☐	☐	Drug Dependence	☐	☐	Nasal Allergies/Hay Fever			
☐	☐	Emphysema	☐	☐	Organ Transplant			
☐	☐	Excessive Bleeding	☐	☐	Osteoporosis			
☐	☐	Epilepsy	☐	☐	Osteoarthritis			
☐	☐	Endocarditis	☐	☐	Pacemaker Type: _____			

Please enter details or any further information: _____

_____

List all drugs/medications you are currently taking (include non-prescription drugs and herbal supplements):

- If you have more than eight medications, please attach a separate list.
- If you cannot remember all your medications, please request that your physician sends us a complete medications list.

1. Name _____ **Dosage** _____
Frequency _____ **Reason** _____
2. Name _____ **Dosage** _____
Frequency _____ **Reason** _____
3. Name _____ **Dosage** _____
Frequency _____ **Reason** _____
4. Name _____ **Dosage** _____
Frequency _____ **Reason** _____
5. Name _____ **Dosage** _____
Frequency _____ **Reason** _____
6. Name _____ **Dosage** _____
Frequency _____ **Reason** _____
7. Name _____ **Dosage** _____
Frequency _____ **Reason** _____
8. Name _____ **Dosage** _____
Frequency _____ **Reason** _____

Are you allergic to or have you had a reaction to any of the following items?

Barbiturates, sedatives, sleeping pills	☐Yes	☐No	Sulfa	☐Yes	☐No
Aspirin	☐Yes	☐No	Clindamycin	☐Yes	☐No
Codeine	☐Yes	☐No	Erythromycin	☐Yes	☐No
Latex	☐Yes	☐No	Dental anesthetics	☐Yes	☐No
Metals	☐Yes	☐No	Food:	☐Yes	☐No
Acrylic	☐Yes	☐No	Other:	☐Yes	☐No
Penicillin	☐Yes	☐No			

Do you take any aspirin daily or any other medication to thin your blood (anticoagulants)? ☐Yes ☐No
Have you ever taken or are currently taking any bone strengthening drugs for treatment or prevention of osteoporosis? ☐Yes ☐No
If yes, what is the name of the medication? _____ Administration route: ☐Oral ☐IV

How long have you been taking it or for how long did you take it? _____

PATIENT DISCLOSURE REGARDING MEDICATION RELATED OSTEONECROSIS OF THE JAW & DENTAL PROCEDURES:

Patients should know that there is a risk of future complications associated with certain dental procedures if they have been, or are currently taking antiresorptive and/or antiangiogenic medications (i.e. Bisphosphonates). These medications can adversely affect the blood supply to bone, thereby reducing its ordinarily excellent capacity to heal. This risk is increased after surgery, especially extractions, implant placement, or other invasive procedures that might cause mild trauma to the bone. Osteonecrosis may result, which is a long-term destruction of the jaw bone that is often very difficult or impossible to eliminate. It is very important to know if you are currently taking or have ever taken these medications: Fosamax (alendronate), Actonel (risedronate), Actonel with Calcium (risedronate with calcium carbonate), Boniva (ibandronate), Zometa or Reclast (zoledronic acid), Aredia (pamidronate), Neridronate, Olpadronate, Didronel (etidronate), Clorodronate, Tiludronate, Prolia/Xgeva (Denosumab), Sutent (Sunitinib), Nexavar (Sorafenib), Avastin (Bevacizumab), Rapamune (Sirolimus) or any other bisphosphonate or bone antiresorptive/antiangiogenic medications.

Have you ever taken any of the above mentioned medications? ☐ **Yes** ☐ **No** If so, please indicate which one of the following statements best applies to you:

-I am presently taking the following Bisphosphonate or antiresorptive/antiangiogenic medications: _____
Since when? _____
-I have taken the following Bisphosphonate or antiresorptive/antiangiogenic medications: _____
For how long? _____

If you have ever been advised against taking any type of medication, please list them: _____

_____

Have you ever had any joint replacement surgery? ☐Yes ☐No

If yes, please indicate the type and date of the surgery _____

Have you been told by your physician that you need to take premedication (antibiotics) one hour prior to dental

appointment? ☐ Yes ☐ No

If yes, please indicate:

Name of antibiotic _____ Dosage _____ Amount _____ Reason for prescription _____

If female, please answer the following:

-Are you taking birth control pills? ☐ Yes ☐ No

-Are you pregnant: ☐ Yes ☐ No If yes, # of weeks: ___

-Are you nursing? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How many cigarettes per day: _____ Number of years _____

Do you use smokeless tobacco? ☐Yes ☐No How many times per day: _____ Number of years _____

Are you wearing a nicotine patch? ☐Yes ☐No **If you quit smoking, how long ago? _____**

Do you drink alcoholic beverages? ☐ Yes ☐ No How many drinks per day: _____ Number of years _____

Do you use any illicit drugs? ☐ Yes ☐ No

Do you suffer from Sleep Apnea or do you use a C-PAP machine? ☐Yes ☐No

Do you wear eyeglasses or contact lenses? ☐Yes ☐No

Have you traveled out of the country in the past 21 days? ☐ Yes ☐No

Are you vegan? ☐Yes ☐No

If yes, are there any materials you would prefer we do not use during your surgeries? Ex. Animal products? _____

Due to religious or personal reasons, are there any materials you would prefer we do not use during your surgeries? (Ex. Animal products from bovine or porcine origins). ☐ Yes ☐No

If yes, please specified what materials you would like us to not use: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or her staff responsible for any errors or omissions that I may have made in completion of this form. I accept full financial responsibility for all services rendered.

Patient Signature: _____ Date: _____

(If under 18, Parent or Guardian Signature required)

Reviewed by: _____

VIRUET
Periodontics & Implants

DENTAL HISTORY FORM

First Name: _____ **Last Name:** _____ **Date of Birth:** ___/___/_____

In the following sections, please select whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you may be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

REFERRING DENTIST: _____ Phone #: _____

CHIEF COMPLAINT: _____

Have you ever had any of the following procedures done?

Extractions	☐Yes	☐No	Root canal therapy	☐Yes	☐No
Fillings	☐Yes	☐No	Gum graft	☐Yes	☐No
Crown and bridges	☐Yes	☐No	Bone graft	☐Yes	☐No
Teeth whitening	☐Yes	☐No	Sinus grafting	☐Yes	☐No
Orthodontic (Braces) Treatment	☐Yes	☐No			
Removable dentures (complete/partial)	☐Yes	☐No	When was your present denture delivered?		
Dental Implants	☐Yes	☐No	If yes, what year implants were placed?		
Wisdom teeth removal	☐Yes	☐No	If yes, how long ago?		

GENERAL HABITS

Do you clench or grind your teeth?	☐Yes	☐No	
Do you bite your lips or cheeks frequently?	☐Yes	☐No	
Do you eat sweets (Ex. Hard candy)?	☐Yes	☐No	If, yes how frequent? _____
Do you drink soda?	☐Yes	☐No	If, yes how frequent? _____
Do you drink coffee or tea?	☐Yes	☐No	If, yes how frequent? _____
Do you chew lemons or other fruits?	☐Yes	☐No	If, yes how frequent? _____
Do you chew ice?	☐Yes	☐No	If, yes how frequent? _____

ORAL HYGIENE HABITS

How often do you brush your teeth? _____ Do you use a manual or electric toothbrush? _____

Brand: _____

How often do you floss? _____

How often do you use a mouthwash? _____

Do you clean under your bridges?	☐Yes	☐No
Do you use interdental brushes?	☐Yes	☐No
Do you use a Waterpik?	☐Yes	☐No
Do you do oil pulling?	☐Yes	☐No

Do your gums bleed while brushing or flossing?	☐Yes	☐No
Are your teeth sensitive to cold, hot, sweets or pressure?	☐Yes	☐No
Do you feel spontaneous pain on any of your teeth?	☐Yes	☐No

Do you have pain on chewing on any of your teeth?	☐Yes	☐No	
Do you have any sores or lumps in or near your mouth?	☐Yes	☐No	
Does food frequently get caught between your teeth?	☐Yes	☐No	
Do you have any loose teeth or have they ever shifted?	☐Yes	☐No	
Do you wear a nightguard?	☐Yes	☐No	
Do you snore when sleeping?	☐Yes	☐No	If yes, do you wear a mouth appliance at night? ☐Yes ☐No
Do you have headaches or migraine?	☐Yes	☐No	
Have you had any pain in your jaw area?	☐Yes	☐No	
Have you ever had difficulty opening or closing your jaw?	☐Yes	☐No	
Does your jaw ever get locked?	☐Yes	☐No	
Have you ever been told you have TMJ problems?	☐Yes	☐No	
Have you ever had a head, neck or jaw injury?	☐Yes	☐No	
Do you suffer from neuralgia?	☐Yes	☐No	
Do you have a gummy smile?	☐Yes	☐No	
Do you have dry mouth?	☐Yes	☐No	
Do you have a history of dental trauma?	☐Yes	☐No	
Have you ever had a biopsy done in your mouth?	☐Yes	☐No	How long ago? _____
Have you ever been diagnoses with Lichen planus, Pemphigus, Pemphigoid or any other soft tissue lesions?	☐Yes	☐No	

PERIODONTAL HISTORY

Have you ever been diagnosed with periodontal ("gum") disease? ☐Yes ☐No

If yes, at what age were you diagnosed? _____

Have you ever had deep cleanings done? ☐Yes ☐No If yes, how long ago? _____

Have you ever had periodontal ("gum") surgery done? ☐Yes ☐No If yes, how long ago? _____

Do you have any family history of periodontal disease? (Grandparents, Parents or Siblings) ☐Yes ☐No

If you have a dental problem, please describe: _____

Do you have any concerns about having dental treatment? ☐Yes ☐No If yes, please explain: _____

Are you happy with the appearance of your teeth? ☐Yes ☐No If yes, please explain: _____

Do you ever feel nervous about visiting a Dentist? ☐Yes ☐No If yes, please explain: _____

GENERAL DENTIST: _____ Phone #: _____

Date of your last x-rays: _____ Date of your last cleaning: _____ Date of your last dental exam: _____

Frequency of your dental maintenance? ___ Every 3 months ___Every 6 months ___Other: _____

Are you a seasonal Florida resident? ☐Yes ☐No If yes, months you are in Florida? _____

Do you see general dentist in another state? ☐Yes ☐No Name: _____ Phone #: _____

Do you see a periodontist in another state? ☐Yes ☐No Name: _____ Phone #: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or her staff responsible for any errors or omissions that I may have made in completion of this form. I accept full financial responsibility for all services rendered.

Patient Signature: _____ Date: _____

(If under 18, Parent or Guardian Signature required)

VIRUET
Periodontics & Implants

Patient Information

Patient Name: _____Date:_____
Last First MI
How do you prefer to be addressed by the doctor and staff?_____
Please circle one: Mr. Mrs. Ms. Miss. Dr. Rev. Other:_____
Date of Birth_____
Address: _____ Home phone:_____
_____ Work phone: _____Ext._____
E-mail _____ Mobile phone: _____
Additional Address: _____
Email _____
Marital Status: Married _____ Single _____ Divorced _____ Widowed _____
In case of emergency please call _____ Phone # _____
Whom can we thank for referring you to our practice? _____
Name of general dentist: _____
Primary dental complaint or reason for referral: _____

Employment Information

Occupation/Former Occupation:_____
Employer Name/Former Employer Name: (please no abbreviations)_____
Employer Address: _____
City: _____ State: _____ Zip Code: _____

Dental Insurance Information

Our insurance coordinator is pleased to assist you in filing insurance claims. Please present your dental and medical insurance cards, driver's license, and full completion of this form. The requested information helps us better serve you in filing dental insurance claims and maximizing insurance benefits.

PRIMARY **Dental Insurance Company _____ Phone # _____**
Claims address _____
Group # _____ Policy or Identification # _____
Name of policy holder _____ Relationship to patient_____
Policy holder birth date ____/____/_____ Policy holder social security # _____
Policy holder's employer _____
Employer's phone #_____ Employer's address _____

Please note that the adult accompanying a minor (under the age of 18) is financially responsible for that patient, no exceptions.
I have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested.
I understand that payment for professional services is the sole responsibility of the patient (parent/guardian if under 18) and is due as services are rendered. We do not render services on the basis that insurance companies will pay our fees, but we will be happy to assist you in filing claims for insurance reimbursement.
I understand that my above insurance coverage is a contractual arrangement between myself and my insurance company and I accept full financial responsibility for all services rendered, regardless of changes in coverage, termination, and/or cancellation of benefits.

Date	Signature of Patient or Parent (if under 18)	Relationship to Patient

VIRUET
Periodontics & Implants

Financial Policy

Payment in full for professional services is ***due at the time dental treatment is provided***. Every effort will be made to provide a treatment plan which fits your timetable and budget, and gives you the best possible care. For your convenience, we accept cash, personal checks, debit cards, Visa, Master Card, American Express, and Discover.

There will be a $25.00 charge to your account for returned checks.

Insurance Coverage:

We do not accept Insurance as a form of payment. While dental insurance is certainly beneficial, it is not a guarantee of payment, as a general rule *dental insurance plans may only pay a small portion of periodontal procedures,* ***depending on policy benefits, annual maximum, and limitations clauses***. As a courtesy to our patients who have dental insurance, we can file a dental claim to your insurance electronically if we are provided with the necessary information. However, we do ask that payment be made in full, and your insurance carrier will be instructed to reimburse you any benefits you may have. Our practice will provide you with a treatment plan that explains the foreseen and recommended treatment that may be incurred. All treatment plans are valid for 3 months. Our patient coordinator will discuss financial arrangements in detail during your consultation appointment.

We strive to remain as flexible as possible by offering a variety of different payment schedules.

Outside Financing:

Care Credit Patient Payment Plan: Financing through Care Credit offers a 6 month differed interest plan. No Interest if Paid in Full within the Promotional Period *

On qualifying purchase of $200 or more made with your Care Credit card account at enrolled provider locations. Interest will be charged to your account (at the rate of 26.99% for new accounts) from the purchase date if the promotional purchase is not paid in full within the promotional period. Please note that this office is not affiliated in any way with Care Credit. We provide you with information about this company only as a courtesy to you.

Wells Fargo: **No Interest For 6 Months If Paid In Full**. This special terms plan is also referred to within the industry as "Deferred Interest" plan. To avoid paying any interest, a Cardholder must pay off the entire purchase balance in full on or before the special terms end date. If the Cardholder does not pay off the purchase balance by the end of the special terms period, the deferred interest from the date of the original transaction will be added to the remaining balance, and the APR for Purchases will continue to apply until the purchase balance is paid in full.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

I have received, read and I understand the Financial Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____	_____	_____
Print Patient Name	Signature of ***patient, parent/guardian*** if under 18	Date

VIRUET
Periodontics & Implants

Appointment No-Show/ Cancellation Policy

At our office we strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment No Show/Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient. We respect and value your time and we ask that you do the same for ours.

In an effort to decrease unnecessary costs related to staffing and supplies and in order to contain our costs and continue to provide you with affordable excellent dentistry, we maintain the following No-Show/Cancellation policy for all of our patients:

We require that you give our office **48 hour notice** in the event that you need to cancel/reschedule your appointment. This allows for other patients to be scheduled into that appointment.

Cancellations must be made during normal business hours on workdays (Monday-Thursday 8:00 AM to 5:00 PM) at least two full business days before the scheduled appointment. Cancellations must be done over the phone by speaking directly to one of our dental professionals. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. Patients will not be charged if cancellation is made 48 business hours before their appointment.

Since we certainly understand that illness or other problems can occur (sometimes without any warning), we will not charge you for your first missed or cancelled appointment. In the event a second appointment is missed or cancelled with less than 48 hours or no notice, a $70 charge will be billed for non-surgical appointments or $300 per hour reserved for surgical appointments.

This fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without the payment of this fee. In order to schedule another surgical appointment you will be required to prepay for your procedure in full.

If a third no-show or same day cancellation occurs, we reserve the right to terminate the doctor-patient relationship as well as another no show/cancellation charges.

If you miss an appointment or do not cancel within 48 hours, it will take 2 years for the records to be cleared. Once cleared, the 2 years will renew if you miss an appointment or do not cancel within 48 hours.

This policy is in effect for all appointments at our office. Please acknowledge that you have had the opportunity to review this policy by signing below.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for allowing us to help you improve your oral health.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of the Appointment Cancellation Policy.

_____ Date: _____

Signature of ***patient, parent/guardian*** if under 18 Date

VIRUET
Periodontics & Implants

34 Barkley Cir
Ft. Myers, FL 33907
239-275-6564
frontdesk@periodontistfortmyers.com

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NPP

I am a patient of KRYSTAL REYES VIRUET, D.M.D. I hereby acknowledge access to review or if requested, receipt of KRYSTAL REYES VIRUET, D.M.D. Notice of Privacy Practices (NPP).

Name [please print]: _____

OR

I am a parent or legal guardian of _____[patient name]. I hereby acknowledge access to review or if requested, receipt of KRYSTAL REYES VIRUET, D.M.D. Notice of Privacy Practices with respect to the patient.

Additionally, _____is authorized by myself to receive any of my information and records.
(Authorized Person)

Signature: _____Relationship to Patient _____Date: _____

****If you do not consent to choose to sign the consent form, 2 members of our staff will sign as witness, to your being issued our Notice of Privacy Practices. Thank You*

Staff Signature #1: _____ Staff Member: _____

Staff Signature #2: _____ Staff Member: _____

VIRUET
Periodontics & Implants

34 Barkley Cir
Ft. Myers, FL 33907
239-275-6564
frontdesk@periodontistfortmyers.com

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

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of November 9, 2015 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing in the following manner:

Viruet Periodontics
34 Barkley Circle
Fort Myers, FL 33907
(239) 275-6564 (Office)
(239) 275-6080 (Fax)

Attention: Administrator