



Billy F. Foxworth, Jr., DMD  
PROSTHODONTIST  
*"Gentle and Compassionate Care"*

The entire team at Dental Associates of East Montgomery would like to take this opportunity to welcome you and thank you for selecting our office to care for your dental needs!

Our goal is to provide each patient with the highest quality dental care in a gentle, efficient and pleasant manner to strongly encourage prevention of future dental problems.

Your first visit to our office normally consists of an examination, periodontal evaluation and necessary x-rays for proper diagnosis, followed by a consultation of your dental needs (unless you have a particular dental problem requiring immediate attention). Treatment fees and financial arrangements will be discussed at this appointment with the office manager.

Please complete both sides of the enclosed patient information and financial agreement and bring these with you on your first visit. Also if you have any dental insurance, please bring your card so we can keep a copy on file. We ask that you arrive 30 minutes early to your agreed appointment time to ensure all information is complete and correct before the doctor sees you.

Should you have any questions, please call at your convenience. Our team is looking forward to meeting you and is eager to assist you!

Welcome!  
Dr. Foxworth, Dr. DuBose and Team

# W

# Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

# Welcome

## Patient Information (Confidential)

Patient Number \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

SS#/SIN \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Separated  Divorced  Widowed

If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_  Full Time  Part Time

Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS#/SIN \_\_\_\_\_

Is this Person Currently a Patient in our Office?  Yes  No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash  Personal Check  Credit Card  VISA  MasterCard  I wish to discuss the office's payment policy.

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

How Much is Your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

**Do You Have Any Additional Insurance?**  Yes  No If Yes, Complete the Following

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

How Much is Your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

Over Please

# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

- |  |   |
|--|---|
| <p>1. Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?<br/>If yes, please explain _____</p> <p>3. Are you taking any medication(s) including non-prescription medicine?<br/>If yes, what medication(s) are you taking? _____</p> <p>4. Have you ever taken Fen-Phen/Redux? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you have or have you had any of the following?</p> | <p>10. Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Are you allergic to or have you had any reactions to the following?</p> <p>Local Anesthetics (e.g. Novocain) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin or any other Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sulfa Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Barbiturates <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any Metals (e.g. nickel, mercury, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Latex Rubber <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Women Only:</p> <p>Are you pregnant or think you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|---|

	Yes	No		Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

# Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

- |   |   |
|---|---|
| <p>1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you feel pain to any of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you had any head, neck or jaw injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever experienced any of the following problems in your jaw?</p> <p>Clicking <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain (joint, ear, side of face) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty in opening or closing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty in chewing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>8. Do you have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you bite your lips or cheeks frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever had any difficult extractions in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you ever had any prolonged bleeding following extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Have you had any orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you wear dentures or partials?<br/>If yes, date of placement _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Do you like your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|---|---|

# Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly

to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X  
Signature of patient (or parent/guardian if minor) \_\_\_\_\_

Doctor's Comments _____ _____ _____	
Signature _____	Date _____

# DENTAL ASSOCIATES OF EAST MONTGOMERY

## PATIENT RESPONSIBILITY FORM

The patient agrees to the following terms and conditions concerning services which are rendered by this office:

1. All fees are due when services are rendered. Payment should be made at the time of each visit.
2. If you have insurance which covers the charges rendered by this office, we will file a claim on your behalf for insurance benefits, accept payments from the insurance company, and apply whatever payments are received to your account. However, it is your ultimate responsibility to pay any and all charges for services rendered by this office whether or not you have insurance, or whether or not the insurance pays the bill. In this regard, you agree that we are not legally responsible for any errors or omissions associated with the filing of any insurance documentations, and that should any questions or problem arise regarding your insurance coverage, you agree to contact your own insurance company and work out any problems or mistakes that may exist. Further, you understand and agree that if this office does file insurance for you, it is something that we do as a courtesy for our patients and that we have no ultimate responsibility or liability if something is not filed correctly.
3. You agree, in order for us to service your account or to collect monies you may owe, Dental Associates of East Montgomery, P.C. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.
4. Your account will be considered past due when it is not paid in full thirty (30) days after date of service. Further, if your account is thirty (30) days past due, it is subject to being turned over to an attorney or collection agency. Further, you agree to pay interest in the amount of eighteen percent (18%) a year.
5. I accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.
6. Should your account be turned over to an attorney for collections, the patient and/or responsible party both agree to pay all costs of collection, including an attorney's fee. The attorney's fee will be based on \$125.00 per hour for all time spent working by the attorney on the collection matter, or one third (1/3) of the balance of the debt turned over to the attorney will spend working on the case after the entry of a judgment, and you agree that the attorney may estimate the total time it will take for him or her to collect the debt to a conclusion, and that you will pay the attorney rate for all time estimated by the attorney that it will take to collect the account, if the attorney's fee is based on an hourly rate. Further, the patient and/or responsible party hereby agrees to waive any rights that they may have to claim any exemptions under the law or the constitution of the Sate of Alabama.
7. We will charge you a service fee on any and all returned checks which is the maximum allowed under the law.
8. The patient hereby agrees and authorizes the doctor and doctor's staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Further, the patient agrees to the use of anesthetics, sedatives, or any other medications as necessary. The patient fully understands that using anesthetic agents embodies certain risks. The patient

understands that he or she can ask for a complete recital of any possible complications prior to the drug being administered.

9. The patient and/or responsible party will only be required to sign one of these agreements. This agreement is valid for the entire duration that the patient and/or responsible party utilizes the services of the office. This agreement applies to any prior treatment, treatment incurred on the date the agreement is signed, or any treatment incurred in the future. Further, the patient and/or responsible party agrees to waive any argument of the statute of limitations if in fact the patient receives services at some point in time which is more than six (6) years from the date this agreement is signed. In other words, this agreement will be signed only one time and will apply to any services provided to the patient or any charges which are owed by the patient or responsible party at any time those services are provided or charges incurred.

10. The person who signs below is the patient, and the patient who signs as the "responsible party" hereby agrees and understands that they will be responsible for any and all outstanding charges incurred by the patient. Further, the responsible party hereby agrees to all the terms and conditions of the patient contract, just as if that person were the patient. Further, both the patient and the responsible party hereby agree to pay any and all charges, interest, and any other fees that may be assessed, including the attorney's fees and collection costs mentioned above, for any and all charges incurred prior to the date this agreement is signed, or any charges incurred subsequent to the date this agreement is signed, as long as the patient remains a patient of the doctor's office.

11. Notice of Cancellation of appointment must be by 2:00 PM two business days prior to appointment or a charge of \$40 will be added to your account. Example: If your appointment is Thursday at 1:00 PM, we must have a notification of cancellation by Tuesday before 2:00 PM.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Responsible Party

Dental Associates of East Montgomery  
210 Winton M Blount Loop  
Montgomery, Al 36117

## Hippa Consent Form

Patient Name: \_\_\_\_\_

Patient Phone #: \_\_\_\_\_

### HIPPA-Notice of Privacy Practice

Hippa is a federal law developed to provide a standard for the protection of your health information.

The purpose of the Notice of Privacy Practice is to explain how Dental Associates of East Montgomery may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPPA regulations. Though Dental Associates of East Montgomery

has always taken great care to protect the integrity and confidentiality of your health care information,

we are now required by the HIPPA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the Notice. Signing below indicates that you have received the Notice of Privacy Practice.

If you have any questions, please contact Dr. Billy Foxworth, Jr. D.M.D.

I hereby acknowledge that I have received a copy of Dental Associates of East Montgomery Notice of Privacy Practices.

\_\_\_\_\_  
Initials of patient/guardian

### Permission to Share Medical Information

My Medical Information may be obtained and exchanged verbally to:

\_\_\_\_\_  
Name/Relationship

\_\_\_\_\_  
Name/Relationship

\_\_\_\_\_  
Initials patient/guardian

Dental Associates of East Montgomery, P.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.

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 (MM/DD/YR), 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.

**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.

**Your Authorizations:** 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 of 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 or 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:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

## 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, we will charge you \$\_\_\_ for each page, \$\_\_\_ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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.

**Restrictions:** 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 locations, 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 of 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 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: **Dr. Billy F. Foxworth, Jr.**

Telephone: **334-272-1677** Fax: **334-2728385**

Address: **210 Winton M. Blount Loop, Montgomery, AL 36117**