4728 S. Campbell Ave. Suite 120 • Springfield, MO 65810 • 417-300-9424 • www.LittleGrinsDental.com

Patient Form Instructions

Our new patient forms allow you to type directly into them. You can also print the forms and fill them out by hand. If you are using the free version of Adobe Reader, you will not be able to save the forms. Here are your options for returning the new patient forms to us:

- **Email**: Once your forms are filled out, you can print the forms, sign them on pages 2, 3, 4, 5, & 6, scan the forms, and email them back to us at office@littlegrinsdental.com

- **Fax**: Once your forms are filled out, you can print the forms, sign them on pages 2, 3, 4, 5, & 6, and then fax them to us at 855-673-2198

- **Mail**: Once your forms are filled out, you can print the forms, sign them on pages 2, 3, 4, 5, & 6, and then mail them to:

  Little Grins Dental
  4728 S. Campbell Suite 120
  Springfield, MO 65810

- **Hand Deliver**: You can drop completed forms by our office anytime in advance of your appointment, or you can bring them with you on your appointment day. (Dropping them off in advance will save you time on the day of your appointment as you will not have to wait for us to enter your information into our system.) Our office hours are 8am to 5pm Tuesday through Friday.

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Patient Registration

Child's First Name: _____ Middle Initial: ___ Last Name: _____

Preferred Name: _____ Child's SSN: _____

Child's Gender: ❑ Male ❑ Female Age: _____ Child's Date of Birth: _____

Reason for seeking dental care? ❑ Routine check-up ❑ Toothache ❑ Cavities ❑ First Dental Visit
❑ Other: _____

Responsible Party ❑ Responsible Party is also the Primary Insurance Holder
❑ Responsible Party is also the Secondary Insurance Holder

First Name: _____ Middle Initial: ___ Last Name: _____

Preferred Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____

Cellular Phone: _____ ❑ I would like to receive Text Message Appt. Reminders

E-mail: _____ ❑ I would like to receive e-mail correspondence

Primary Dental Insurance

Policy Holder's First Name: _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SSN: _____

Employer: _____ Employer Phone #: _____

Employer Address: _____ City: _____ State: _____ ZIP: _____

Ins. Company: _____ Ins. Co. Phone #: _____

Ins. Group #: _____ Member ID #: _____

Secondary Dental Insurance

Policy Holder's First Name: _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SSN: _____

Employer: _____ Employer Phone #: _____

Employer Address: _____ City: _____ State: _____ ZIP: _____

Ins. Company: _____ Ins. Co. Phone #: _____

Ins. Group #: _____ Member ID #: _____

Medical History

Primary Care Provider (Medical Doctor):_____ Phone:_____

Previous Dentist:_____ Referring Doctor:_____

Is your child presently under the care of a physician for any medical condition? ❑Yes ❑No ❑Unknown

If yes, please explain:_____

Has your child ever had a serious illness or operation? ❑Yes ❑No ❑Unknown

If yes, please explain:_____

Is your child currently taking any medications? ❑Yes ❑No ❑Unknown

If yes, please list all medications including over the counter and herbal according to dose and frequency:

Medication	Dose	Frequency	Reason (Behavior, Asthma, etc)

Is your child allergic to any of the following? ❑None

❑Aspirin ❑Penicillin ❑Codeine ❑Local Anesthetics ❑Acrylic ❑Metal ❑Latex ❑Sulfa Drugs

Does your child have a food allergy? ❑Yes ❑No If yes:_____

Does your child have an allergy not listed above? ❑Yes ❑No If yes:_____

Does your child have, or have had, any of the following?

(Many of these don't apply to children; however, we are required to ask.)

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Sickle Cell Trait	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Yellow Jaundice	Yes No
ADHD	Yes No	Autism	Yes No	Learning Disability	Yes No	Down's Syndrome	Yes No
Behavior Concerns	Yes No	Autistic Tendencies	Yes No	Speech Delayed	Yes No	Special Needs (Other)	Yes No

If yes to any of the above, please explain:_____

Has your child had any illness not listed above? ❑Yes ❑No If yes, please list:_____

_____

To help better serve your child, are there any additional thoughts or concerns about your child?_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform Little Grins Dental of any changes in medical status.

Signature of Parent/Guardian:_____ Date:_____

Dental History

How long has it been since your child's last dental check-up?_____

Has your child had any unpleasant experiences in a dental office? ❑Yes ❑No ❑Unknown

If yes, please explain:_____

Is your child complaining of any teeth, gums or mouth pain? ❑Yes ❑No ❑Unknown

If yes, please explain:_____

Does your child drink Soda Pop / Soft Drinks? ❑Yes ❑No ❑Unknown If yes, how often:_____

How often does your child brush their teeth?

❑Once a day ❑Twice a day ❑Three times a day ❑When remembered ❑Unknown

Is teeth brushing supervised? ❑Yes ❑No ❑Unknown If yes, by whom:_____

Does your child have a history of prolonged pacifier use (past 18 months)? ❑Yes ❑No

Does your child have a history of prolonged finger or thumb sucking (past 18 months)? ❑Yes ❑No

Is your child currently nursing? ❑Yes ❑No

Emergency Contact

First Name:_____ Last Name:_____ Relationship:_____

Phone Number:_____ E-mail:_____

Referring Family or Friend

First Name:_____ Last Name:_____

Phone Number:_____ E-mail:_____

Consent for Examination

I hereby authorize an initial examination by Dr. Craig Rechkemmer, DDS. An initial examination will include dental x-rays, cleaning, fluoride and diagnosis of oral health problems. I understand that the practice of dentistry is not an exact science. I acknowledge that no guarantees have been made to me as to the results of treatment or examination at Little Grins Dental, LLC.

I understand that after the examination, cleaning, fluoride and x-rays have been evaluated by the dentist; I will receive a Treatment Plan for my child. If I agree with the Treatment Plan; I will need to complete the Treatment Plan consent form before any additional dental treatment can be provided.

I hereby and on behalf of above listed child who is under the age of eighteen (18) years, consent that said child may participate in the dental services provided by Dr. Craig Rechkemmer (d/b/a/ Little Grins Dental, LLC).

The undersigned further hereby consents and authorizes the agents and employees of Little Grins Dental to file and collect reimbursement for dental services performed.

Yes	No	
❑	❑	1. Are you currently the legal guardian for this child?
❑	❑	2. Can you sign for Medical/Dental Treatment?

PARENT/GUARDIAN ACKNOWLEDGEMENT I acknowledge that I have read (or have had read to me) and fully understand the above consent, any explanations requested were explained, and all blanks requiring completion were filled in before I affixed my signature.

Print Parent/Guardian Name:_____ Relationship to Child:_____

Signature Parent/Guardian:_____ Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I acknowledge that I have received the Notice of Privacy Practices for Little Grins Dental, LLC.

Parent /Guardian of: _____

Signature: _____

Print Name: _____

Relationship to Patient: _____

Date: _____

This document will become a permanent part of the patient's Medical/Dental Record.

I refuse to sign this acknowledgement.

Print Name: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

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Appointment Policy

Little Grins Dental strives to be on-time, efficient and respectful of your time. When your appointment is scheduled, a room is reserved, your records are reviewed and special instruments are prepared before your arrival. You can expect Little Grins Dental to be prompt unless we are providing emergency treatment for another patient.

Due to our limited number of available appointments, we ask that you contact us before your scheduled appointment to reschedule or cancel. If we are given enough notice, we can offer your appointment time to a family that is on the waiting list.

If you miss or reschedule within 24 hours of your scheduled appointment, Little Grins Dental will require a $60 deposit in order to reschedule your appointment. The $60 deposit will be refunded at the next appointment. If a consecutive appointment is missed or is rescheduled with less than a 24 hour notice, then an additional $60 deposit will be required to reschedule. In that situation, only $60 total will be refunded at the next appointment and not $120. If a third appointment is missed or rescheduled with less than a 24 hour notice, then it will be necessary to categorize that patient as inactive and will only be scheduled from the waiting list.

I hereby certify that I understand the appointment policy and the reasons for the rescheduling appointment deposit. I acknowledge that every effort will be made to arrive promptly for appointments and that I will contact Little Grins Dental with any schedule changes before the scheduled appointment.

Print Parent/Guardian Name: _____ Relationship to Child: _____

Signature Parent/Guardian: _____ Date: _____

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Payment Policy

Little Grins Dental is a general dental practice where dental insurance is welcomed and accepted. Payment 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 your child the best possible care. If payment is not received from your dental insurance company within 45 days from the date of service then you will be responsible for payment for all dental services provided. All balances over 60 days are subject to a 5% service charge. Delinquent accounts over 90 days will be forwarded to a collection service and you will be responsible for all related costs.

Insurance Plans
Little Grins Dental will process insurance forms electronically which enables the claim to be paid within 30 days of receipt. We recommend you verify your annual maximum with your insurance company. Once you exceed your annual maximum, payment in full is expected at the time of service. Co-payments are collected at the time of visit.

We are currently a dental provider for:

Aetna PPO	Assurant PPO	Cigna	Delta Dental Premier & PPO
Humana PPO	MetLife (MetDental)	United Healthcare	-

Payment for services from the above listed dental insurance companies will go directly to Little Grins Dental. Any overpayment or refunds will be handled accordingly on a case-by-case basis.

Families with other Dental Insurance Plans
Little Grins Dental can file an electronic claim for most dental insurance companies not listed above. In those situations, full payment is collected at the time of visit and the reimbursement money from your insurance company is sent directly to you. Please keep in mind that we file those dental insurance claims as a courtesy to our families. We do not have a contract with dental insurance companies that are not listed above and therefore are not responsible for what benefits they pay on a claim. The insurance reimbursement that is sent directly to you may not cover the entire cost of treatment provided at Little Grins Dental since we are not enrolled in their dental insurance program.

Families without Dental Insurance
Little Grins Dental offers a payment plan through CareCredit. CareCredit is a GE Money Company card that allows you to finance treatments with special financing, low monthly payment options, no up-front costs and no-prepayment penalties. This payment plan is accepted by over 90,000 providers and will allow you to continue treatment without delay due to financial constraints. You can apply for CareCredit online, or the Little Grins Dental team can help process your application in person.

We accept cash, checks, Visa, MasterCard, Discover, and American Express. Personal checks are processed electronically and will withdraw from your checking account on the date of service.

Child Custody Agreements and Court Orders

Little Grins Dental understands that many families may have child custody agreements or court orders regarding the fiduciary responsibility of a child's medical and dental care. However, Little Grins Dental will not become involved in any custody or financial responsibility disputes. The parent or guardian that brings the child to Little Grins Dental is legally responsible for the payment of all fees regardless of any custody agreements or court orders.

Print Parent/Guardian Name: _____ Relationship to Child: _____

Signature Parent/Guardian: _____ Date: _____

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Playground & Play Area Consent

I, the parent/legal guardian of the child, am aware that participation in the indoor Little Grins Dental, LLC playground and/or use of the play area creates a risk of injury, and I, on behalf of myself and child, knowingly and freely assume all such risks, both known and unknown, even if arising from the negligence of others; and

I agree that the child and I shall comply with the rules and conditions for the indoor Little Grins Dental, LLC playground. In addition, if I observe any hazard during our participation, I will bring it to the attention of the Little Grins Dental staff.

I, for myself and the child, hereby release and hold harmless Little Grins Dental, LLC, their affiliates, officers, members, agents, employees, and other participants from and against any and all claims, injuries, liabilities or damages arising out of or related to participation with the indoor Little Grins Dental, LLC playground and play area.

PARENT/GUARDIAN ACKNOWLEDGEMENT I acknowledge that I have read and fully understand the above consent and any explanations requested were made - before I affixed my signature.

Print Parent/Guardian Name: _____ Relationship to Child: _____

Signature Parent/Guardian: _____ Date: _____

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Dental Patient Consent and Release Regarding COVID-19

Novel Coronavirus ("COVID-19") has had wide-ranging impacts on our everyday lives, including here at Little Grins Dental, LLC ("The Practice"). As we transition back to providing dental care, the health and safety of staff and patients remains our top priority.

Precautions. The Practice has implemented , as appropriate, the Center for Disease Control's ("CDC") Guidance on Returning to Work as well as guidance by state and local health departments, and applicable state licensing agencies ("the Precautions"). Some of the Precautions may include: regular screening of employees and pre-appointment screening of patients for respiratory illness indicators; limiting non-patient visitors to essential ones such as suppliers and barring family members and friends of patients as appropriate; practicing social distancing with staff and patients where possible; expanding the wearing of masks and other Personal Protective Equipment ("PPE"); rigorous cleaning and sanitizing of our work space, tools, and instruments; responding quickly and effectively to isolate exposed areas and people when a staff member or patient becomes sick; and, making reasonable efforts to assist with contact tracing and notifications where appropriate. Additionally, because dental procedures which use dental instruments such as handpieces, ultrasonic scalers, and air-water syringes create a spray which may contain contaminated droplets and aerosols, some of the Precautions may include transmission-based precautions published by the CDC and/or state licensing agencies, in addition to standard precautions. As guidance and circumstances change so may The Practice's Precautions.

Consent. By signing this form, I acknowledge and understand that the implementation of some of the Precautions may change as circumstances warrant and that due to the nature of COVID-19, The Practice does not guarantee that I or my child will not be exposed to COVID-19 or expose others if I unknowingly have COVID-19. Despite the risk that I could unintentionally be exposed to COVID-19 at The Practice, I agree and consent to receiving dental care for my child at The Practice. If I have questions about the Precautions in place, I understand The Practice will answer them to the best of its ability.

Release. In consideration for the Precautions taken by The Practice to reduce the risk of possible exposure to COVID-19, in consideration for receiving dental care for my child at The Practice, and in consideration of the risk posed to The Practice and its staff in providing me dental care if I or my child unknowingly have COVID-19, **I hereby knowingly and voluntarily RELEASE AND FOREEVER DISCHARGE (for myself, my heirs, executors, administrators, and assigns) The Practice (its present and former owners, officers, directors, providers, employees, agents, and representatives (including volunteers), successors and assigns, any affiliates, and its direct or indirect owners), from any and all**

liability, claims, suits, actions, causes of action, crossclaims, counter-claims, compensatory damages, liquidated damages, punitive or exemplary damages, other damages, claims for costs and attorney's fees, or liabilities or any nature whatsoever and demands of whatever kind or nature, either in law or in equity, for or because of any illness and injury I might incur from unintended exposure to COVID-19 while I or my child is at The Practice and because of any negligence or fault The Practice arising directly or indirectly from the Precautions.

In executing this document, IT IS MY INTENT to release all claims of any kind or character, including negligence claims, which I might have now or in the future against The Practice arising out of any illness or injury I or my child might incur from unintended exposure to COVID-19 at The Practice and from any because of any negligence or fault of The Practice arising directly or indirectly from the Precautions.

I have read the above. I fully understand it, and my questions have been answered to my satisfaction.

Print Parent/Guardian Name: _____ Relationship to Child: _____

Signature Parent/Guardian: _____ Date: _____

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COVID-19 Pandemic
Dental Treatment Consent Form

Even after following protocols set by the American Dental Association and our state's dental association, it is still possible to contract COVID-19 while at a dental office. We are following all guidelines to minimize the risk of transmission.

- I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic for my child. I understand that the COVID-19 virus has a long incubation period during which carriers of this virus may not show symptoms and may still be highly contagious. _____ (Initial)
- I understand that due to the frequency of visits of other dental patients, the characteristics of the COVID-19 virus, and the characteristics of dental procedures I and/or my child have an elevated risk of contracting the COVID-19 virus simply by being in a dental office. _____ (Initial)
- I confirm that I am, nor my child, is not presenting any of these COVID-19 symptoms: _____ (Initial)
  - Fever
  - Shortness of breath
  - Dry cough
  - Runny nose
  - Sore throat
- I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least six feet for a period of 14 days to anyone who has recently traveled, and this is not possible with dentistry. _____ (Initial)
- I verify that I, nor my child, have not traveled outside the United States in the past 14 days. _____ (Initial)
- I verify that I, not my child, have not traveled domestically within the United States by commercial airline, bus or train within the past 14 days. _____ (Initial)

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Signature: _____ Today's Date: _____

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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 June 7, 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. 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. If you pay in full for services out of pocket, you have the right to request our office not to disclose treatment information for these services to a health plan.
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 Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your Protected Health Information (PHI) for marketing or fundraising communications without your written authorization. You have the right to opt out of these communications.
Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence,

counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Breach Notification Rule: In the event of a breach of PHI, our office will notify you regarding the unsecured PHI breach.
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 $1.00 for each page 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.) You have the right to an electronic copy for your records that is sent directly to you, provided that your email address is verified and you acknowledge there are security risks when emailing sensitive information.
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. *(You must make your request in writing).* Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Craig Rechkemmer, DDS
Telephone: 417–300–9424
Fax: 855-673-2198
E-mail: Office@LittleGrinsDental.com
Address: 4728 S. Campbell Ave. Suite 120, Springfield, MO 65810

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