Aesthetic Smiles
Maryam M. Motlagh, D.M.D., P.C.
13765 NW Cornell Road, Suite 100
Portland, OR 97229
503-643-9855 503-626-7154 (fax)
www.aesmiles.com

Dear Patient,

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. We are serious about providing superior dental care at reasonable prices, and proud of our dedication to our patients. Our goal is to help you feel and look your very best through excellent dental care.

Your appointment, will take approximately 60-minutes. To facilitate being seen just as soon as possible at the time of your appointment, we would be grateful if you would complete the enclosed Patient Information Forms prior your arrival and **bring them with you to your appointment.**

Your appointment will consist of the following:

- Diagnostic Radiographs
- Gum disease evaluation
- Tooth decay assessment
- TMJ Occlusion Evaluation
- Head and Neck Cancer Screening
- Blood pressure check
- Review of Medical and Dental History

I will work with you to plan your treatment and identify any needed follow-up appointments, **including cleanings.**

If you are unable to make the appointment you have scheduled with us, please notify us at least 24 hours in advance. We would be glad to reschedule the appointment at a more convenient time. In the meantime, we look forward to meeting you and serving your needs.

Thanks again for choosing our dental practice.

Sincerely,

Maryam M. Motlagh D.M.D., PC

P.S. Please remember to bring your insurance ID cards with you to your appointment.

Aesthetic Smiles

Maryam M. Motlagh, D.M.D., P.C.

WELCOME! Those of us here at Aesthetic Smiles believe in giving you the best possible dental care. We want you to feel welcome and as comfortable as possible throughout your treatment. This includes understanding your treatment plan as well as our financial policy.

FINANCIAL AGREEMENT:

Many people think that if they have dental insurance, it is the insurance company, which owes the doctor for their services. This is not the case. The dental insurance contract is **between the patient and the insurance company**. Therefore, the **patient is responsible for the bill**, regardless of the insurance coverage. As a **courtesy** to our patients, we will bill your insurance company. However, the responsibility for payment will remain with you. In order for us to bill your insurance, you must supply us with complete information about your coverage including any necessary forms and group numbers

Insured dental patients are expected to pay the **estimated non-insurance portion at the time of service**. Most dental insurance plans do not cover 100% of the cost of your treatment. If the insurance has not paid within 60 days of treatment, you will need to make full payment to this office and be reimbursed when your insurance pays. We will mail monthly statements to all patients with an outstanding balance. Unpaid balances over 90 days will be assessed a finance charge of 18% per annum.

Patients who are **not insured** are expected to pay fees in full at the time of service unless prior arrangements have been made. Payments may be made with cash, check, Visa, MasterCard or Care Credit. . If payment is made by credit card or Care Credit and for any reason, you desire a refund, a merchant processing fee will be deducted from your refund amount.

In the event that your dental account becomes delinquent and is turned over to a collection agency, you will be charged a $75.00 administrative fee.

IF YOU ARE INSURED:

1. Please be familiar with the coverage and deductible on your insurance plan(s). To help you better understand your dental benefits, read your booklet, call your employer/personnel department, or insurance company.

2. Please bring your insurance card and/or completed insurance form with you on your first visit.

An often-misunderstood term used by many insurance companies is Usual, Customary and Reasonable (UCR). This is an arbitrary fee ceiling at which the insurance company will stop reimbursement. After this ceiling, coverage for a particular procedure will cease. Again, this has nothing to do with the fee charged, but with the level of coverage negotiated by the policyholder.

PLEASE SIGN AND RETURN TO RECEPTIONIST

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it become necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment of benefits.

WE APPRECIATE YOUR TRUST AND CONFIDENCE in our office. Our goal is to make your visits as pleasant as possible. If you have any questions, problems or suggestions concerning your treatment or our policies, please do not hesitate to ask our staff.

If you need to cancel your appointment, give at least a **full 24-hour notice** to avoid a **$50.00 fee**.

Signature_____ Date_____

WELCOME

Date_____

Patient's Name_____ ❑Male ❑ Female
Last First Initial Date of birth

If Child: Parent's Name_____

How do you wish to be addressed_____

Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

Home Address_____

City_____State_____ Zip_____

Telephone - Home_____ Work_____ Cell/pager_____ Fax_____

Email_____

Spouse Name_____ Birthdate_____

Who is responsible for this account?_____

Method of payment: Insurance ❑ Cash/Check ❑ Credit Card ❑

Purpose of today's visit_____

How did you hear about Aesthetic Smiles Smiles?_____

Someone to notify in case of emergency not living with you_____

Insurance Information

Primary Insurance Company_____

Claims Address_____

ID or Member #_____ Group or Local #_____ Telephone #_____

Insured SS#_____

Employee Name_____ Date of Birth_____

Employer_____ Yrs_____

Secondary Insurance Company_____

Claims Address_____

ID or Member #_____ Group or Local #_____ Telephone #_____

Employee Name_____ Date of Birth_____

Employer_____ Yrs_____

RELEASE:

I consent the dentist to perform diagnostic procedures and treament by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and healthcare operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care._____

My consent to disclosure of records shall be effective unitl I revoke it in writing.

I authorize payment o directly to the dentist or dental group of insurance benefits, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accurancy of the information on this page.

PATIENTS OR GUARDIAN'S SIGNATURE_____ Date_____

REGISTRATION

WELCOME

Patient's Name_____
Last First Initial Date of birth

COMMENTS

1 Purpose of initial visit_____
_____
2 Are you aware of a probem?_____
_____
3 How long since your last dental visit?_____
4 What was done at that time?_____
_____
5 Previous dentist's name_____
Address:_____ Ph #_____
6 When was the last time your teeth were cleaned?_____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER
PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

7 Have you made regular visits?..... Yes or No
8 Were dental x-rays taken?..... Yes or No
9 Have you lost any teeth or have any teeth been removed?..... Yes or No
Why?_____
10 Have they been replaced?..... Yes or No
11 How have they been replaced?
a. Fixed Bridge_____Age_____
b. Removable Bridge/Partial Denture_____ Age_____
c. Denture_____Age_____
d. Implant_____Age_____
12 Are you unhappy with the replacement?..... Yes or No
If yes, explain_____
13 Would you like to know about permanent replacements?..... Yes or No
14 Have you ever had any problems or complications with previous dental treatment?..... Yes or No
If yes, explain_____
15 Do you grind or clench your teeth?..... Yes or No
16 Does your jaw click or pop?..... Yes or No
17 Have you experienced any pain or soreness in the muscles of your face or around your ear?..... Yes or No
18 Do you have frequent headaches, neckaches or shoulder aches?..... Yes or No
19 Does food get caught in your teeth?..... Yes or No
20 Are your teeth sensitive to: ❒Hot? ❒Cold? ❒Sweets? ❒Pressure?
21 Do your gums bleed or hurt?..... Yes or No
When? _____
22 How often do you brush your teeth?_____ When?_____
23 Do you use dental floss?..... Yes or No
How ofter?_____
24 Are any of your teeth loose, tipped, shifted or chipped?..... Yes or No
25 Are your unhappy with the appearance of your teeth?..... Yes or No
26 How do you feel about your teeth in general?_____
27 Do you feel your breath is offensive at times?..... Yes or No
28 Have you ever had gum treatment or surgery?..... Yes or No
What?_____
Where?_____
When?_____
29 Have you ever had any orthodontic work?_____
30 Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?_____

I CERTIFTY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN SIGNATURE_____ DATE_____

DENTIST SIGNATURE_____ DATE_____

DENTAL HISTORY

WELCOME

Patient's Name_____
Last First Initial Date of birth

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER
PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

1 Physician's Name_____
Address_____
_____ Tel: ( )_____

2 Are you under a physician's care?..... Yes or No
Since when_____ Why_____

3 When was your last complete physical exam?_____

4 Are you taking any medication or substances?..... Yes or No
(If yes, please list medications in comments section or on the back of this form..... Yes or No

5 Do you routinely take health related substances? (Vitamin, herbal supplements, natural product) Yes or No

6 Are you allergic to any medications or substances? (please list)..... Yes or No

7 Do you have any other allergies or hives?..... Yes or No

8 Do you have any problems with penicillin, antibiotics, anesthetics or other medications?... Yes or No

9 Are you sensitive to any metals or latex?..... Yes or No

10 Are you pregnant or suspect you may be? Due Date_____ ..... Yes or No

11 Do you use any birth control medications?..... Yes or No

12 Have you ever been treated for or been told you might have heart disease?..... Yes or No

13 Do you have a pacemaker or an artificial heart valve implant?..... Yes or No

14 Have you ever had rheumatic fever?..... Yes or No

15 Are you aware of any heart murmurs?..... Yes or No

16 Do have high or low blood pressure? (Please circle) ..... Yes or No

17 Have you ever had a serious illness or major surgery?..... Yes or No
If yes, please explain_____ Yes or No

18 Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?..... Yes or No

19 Do you have inflammatory diseases, such as arthritis or rheumatism?..... Yes or No

20 Do you have any artificial joints prosthesis?..... Yes or No

21 Do you have any blood disorders, such as anemia, leukemia, etc?..... Yes or No

22 Have you ever bleed excessively after being cut or injured?..... Yes or No

23 Do you have any stomach problems?..... Yes or No

24 Do you have any kidney problems?..... Yes or No

25 Do you have any liver problems?..... Yes or No

26 Are you diabetic?..... Yes or No

27 Do you have fainting or dizzy spells?..... Yes or No

28 Do you have asthma?..... Yes or No

29 Do you have epliepsy or seizure disorders?..... Yes or No

30 Do you have venereal disease?..... Yes or No

31 Have you tested HIV positive?..... Yes or No

32 Do you have AIDS?..... Yes or No

33 Have you had or do you test positive for hepatitis?..... Yes or No

34 Do you or have you had T.B.?..... Yes or No

35 Do you smoke, chew, use snuff or any other form of tobacco?..... Yes or No

36 Do you consume alcoholic beverages?..... Yes or No

37 Do you habitually use controlled substances?..... Yes or No

38 Have you had psychiatric treatment?..... Yes or No

39 Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine, (redux), or other weight loss products?..... Yes or No

40 Do you have any disease condition, or problem not listed? If so, explain_____
_____ Yes or No

41 Is there anything else we should know about your health that we have not covered in this form?
_____

42 Would you like to speak to the Doctor privately about any problem?..... Yes or No

COMMENTS

I CERTIFTY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN SIGNATURE_____ DATE_____

DENTIST SIGNATURE_____ DATE_____

MEDICAL HISTORY

Aesthetic Smiles
Maryam M. Motlagh, D.M.D., P.C.
13765 NW Cornell Rd., Suite 100
Portland, OR 97229
(503) 643-9855

At Aesthetic Smiles, we evaluate more than just your teeth and gums. Being trained as a neuromuscular dentist, Dr. Motlagh will evaluate the bite, joints and muscles of head and neck that are affected by your bite.
One or more of the following symptoms may be indicative of musculoskeletal Dysfunction of the head and neck. If you have any of the following symptoms, please indicate by checking the appropriate areas. (L = Left, R = Right)

a. Pain in the jaw joint __L R__
b. Pain in the ear __L R__
c. Pain around eyes __L R__
d. Pain in lower jaw __L R__
e. Pain in upper jaw __L R__
f. Pain in neck __L R__
g. Pain in shoulder __L R__
h. Pain in forehead __L R__
i. Pain in temples __L R__
j. Pain in facial muscles __L R__
k. Facial muscle twitch __L R__
l. Subjective hearing loss __L R__
m. Clicking or popping __L R__
sound in joint (circle which
n. sounds most descriptive.)
Grating sound in joint __L R__
o. Dizziness (Vertigo) __Yes No__
p. Ringing in the ears __L R__
q. Fullness, pressure
blockage in the ear __L R__

r. Headache __Yes No__
Tension headaches __Yes No__
Migraines __Yes No__
How often? _____
Top of head __Yes No__
Forehead __Yes No__
Temples __Yes No__
Behind eyes __Yes No__
s. Partial inability
to open mouth __Yes No__
t. Difficulty chewing/
swallowing __Yes No__
u. Pain in tongue __Yes No__
v. Difficulty breathing __Yes No__
w. Constantly tired __Yes No__
x. Mouth breather at night __Yes No__
y. Have you had any injury
to the jaw or face __Yes No__
z. Do you know if you
clench or grind your teeth __Yes No__

What aspect of your condition concerns you most?

_____
_____
_____

Patient's Name_____Date_____

Aesthetic Smiles

PRIVACY NOTICE ACKNOWLEDGEMENT

To Our Patients:

Federal law requires that we provide you with a copy of our Privacy Notice.

The Privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice.

If you have questions about the Privacy Notice, please feel free to direct these to our Privacy Officer at any time. The name and contact number of the Privacy Officer is listed on your copy of the Privacy Notice.

Patient Name:_____ Date of Birth:_____

Patient to complete this section

I have received a copy of the Privacy Notice for this organization on today's date.

Signed:_____ Date: _____

If patient is unable to acknowledge receipt, staff member providing notice to complete this section

The Privacy Notice was provided to

Patient Name:_____ On _____

The patient was unable to acknowledge receipt of the Privacy Notice for the following reason:

_____
_____
_____

Signed:_____

File this form in the patient's chart

Aesthetic Smiles

PRIVACY NOTICE

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

PLEASE REVIEW IT CAREFULLY.

Our organization is committed to providing you with medical care that meets your needs. An important aspect of our service commitment to you is the protection and security of the protected health information that we obtain about you. We have always safeguarded your health information and our written privacy policy gives us an opportunity to share with you our policies that protect your health information.

We are required by law to provide you with this notice. It will describe to you what protected health information we collect about you and how that information might be used.

The Type Of Protected Health Information That We May Obtain About You:

Demographic Information: including your name, address, date of birth, phone number(s), name of your employer, your spouse or other family members, and emergency contact.

Insurance Information: including your insurance carrier, the name of the insured person, insurance identification numbers, and benefits and eligibility information.

Health Information: including your health history, past illnesses or injuries, family medical history, your social activities including use of tobacco, alcohol, or drugs, family life and living situation, your current and/or ongoing health problems, including medications, allergies, advised treatment and outcomes of that treatment.

Payment Information: including your insurance carrier, your record of charges, adjustments, and payments to our organization.

How We May Use and Disclose Protected Health Information About You:

Section 1:
We are not obligated to have your consent when using or disclosing protected health information for the following purposes:

A. **For Treatment:** We may use and disclose your health information to provide, coordinate or manage your health care and any related services. We may disclose information about you to doctors, dentists, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example:
- ◊ *If we schedule a test, therapy or surgery for you, we must provide information about you in order to complete the scheduling. This includes your name, demographic and insurance information and the reason for the test.*
- ◊ *Your doctor may share your medical information with another doctor who is also involved in your care so that both may have all the information to make the best treatment decisions for you.*
- ◊ *We may share information with a pharmacy so that they can fill or refill a prescription for you.*
- ◊ *We may share information about you with another provider who is on call in the absence of your provider.*

B. **For Payment:** We may use and disclose your information to obtain payment for services you receive. If you pay in full for service out of pocket you have the right to restrict your information being given to any health plan.

For example:
- ◊ *We may use or disclose your information to determine eligibility for insurance or benefits.*
- ◊ *We may use the name of your insurance carrier and your identification numbers in order to file a claim for you.*
- ◊ *We may disclose your information about your conditions or reasons for seeking care and the care that is provided to your insurance carrier so that they may process and pay your claim.*
- ◊ *We may disclose information about your conditions to your insurance carrier to seek approval as necessary for recommended tests and treatment.*
- ◊ *We may provide information about your services to a health care clearinghouse so that they may distribute a claim to your insurance carrier on our behalf.*

◊ *If we refer you to another facility or provider we may provide them with your insurance information to expedite your registration and assure that they are participants in your insurance plan.*

C. **For Health Care Operations:** We may use or disclose protected health information about you in order to evaluate our care for you or to meet a business need of the organization. These activities include quality assessment activities, employee review activities, training students, compliance audits by your insurance carrier, and conducting or arranging for other business activities.

For example:
◊ *We may use information about you to evaluate the performance of our staff in caring for you.*
◊ *We may use your information to evaluate our efficiency.*
◊ *We may use your information to evaluate and respond to a patient complaint.*
◊ *We may share your health information with students or residents who are learning to care for patients.*

We may also use or disclose protected health information to our Business Associates in the performance of health care operations. A Business Associate is an entity or person engaged by this organization to perform a business activity on behalf of the organization. Our Business Associates are obligated by contract to protect health information they receive or generate about you.

For example:
◊ *We may provide information to our transcription service so that they can produce a written copy of your encounter in our office.*
◊ *We may provide information to our accountant in order to prepare our organization's financial reports.*
◊ *We may share information with qualified consultants in order for them to provide business management advice.*

D. **Other Contact Situations:**
◊ We may use your information to call and remind you of an appointment in our office.
◊ We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.
◊ We may tell you about health-related products or services that may be of interest to you.
◊ We may use your information for marketing, and fund raising you do have the right to opt out of the marketing and fund raising information.

E. **Special Situations:**
Emergencies: We may use or disclose protected health information in the case of a medical emergency.

Required by Law: We may use or disclose your protected health information if the disclosure is required by law.

Public Health: We may disclose protected health information about you for public health activities. These activities generally include the following:
◊ To prevent or control disease, injury or disability
◊ To report births or deaths
◊ To report child abuse or neglect
◊ To report reactions to medications or problems with products
◊ To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
◊ To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight: We may disclose protected health information to health oversight agencies that oversee our activities. These activities may include audits, investigations and inspections and are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits or Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. Subject to legal requirements, we may also disclose medical information about you in response to a subpoena.

Law Enforcement: We may disclose protected health information, so long as all applicable legal requirements are met, for law enforcement purposes.

Coroners, Medical Directors and Funeral Directors: We may disclose protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release information about patients to funeral directors as necessary to carry out their duties.

Workers Compensation: We may disclose medical information about you for programs that provide benefits for work-related injuries or illness.

Military Activities, National Security and Intelligence Activities: If you are a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to disclose protected health information about you. We may also disclose information about foreign military personnel to the appropriate foreign military authority.

Organ and Tissue Donation: If you are an organ or tissue donor, we may disclose protected health information to organizations that handle organ or tissue procurement when necessary to facilitate organ or tissue donation or transplantation.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. The release would be necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use or disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Information that is not personally identifiable: We may use or disclose information about you in a way that does not personally identify you.

Section 2:
Protected Health Information Use and Disclosure That Requires an Opportunity for You to Agree or Object

Family and Friends: We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment of your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

Section 3:
Protected Health Information That Cannot Be Disclosed Without Your Specific Authorization:

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

You may revoke this authorization by notifying us in writing at any time.

Your Rights as a Patient:

◊ **You have the right to inspect and copy your protected health information.**
You may inspect and obtain a copy of your protected health information maintained in our office. We may charge you for the cost of copying, mailing or associated supplies.

Under federal law, however, you may not inspect or copy psychotherapy notes or information compiled in reasonable anticipation of a civil, criminal or administrative action or proceeding. Certain documents pertaining to laboratory services are also exempt under federal law.

You have the right to an electronic copy of your records however this office does not have electronic records. However we will copy your paper chart if requested in writing.

You have the right to request your records be sent via e-mail with the understanding that we will try and verify your email before sending. E-mail is not always secure and you are acknowledging this fact. This request must be done in writing.

Under certain circumstances, we may not grant your request. If we deny your request, then you may appeal our decision.

We require that requests to access your protected health information be made in writing. You can arrange to do this through our Privacy Officer.

◊ **You have the right to request a restriction of your protected health information.**
You may ask us not to disclose your protected health information for treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to friends and/or family members involved in your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency care.

In order to request a restriction, you must do so in writing. The request must specifically state what information is restricted and to whom the restriction applies.

You may request a restriction form from our Privacy Officer.

◊ **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**
You may request that we communicate with you in a certain way or at a specific location. We will attempt to accommodate all reasonable requests.

Please contact our Privacy Officer to make this request in writing. Your request must specify where or how the communication is to be directed.

◊ **You have the right to request that we amend your protected health information.**
If you believe that protected health information we have about you is incorrect or incomplete, you may request an amendment to this information.

We may not grant your request if we determine that the protected health information that is the subject of your request:
- ◊ was not created by our organization
- ◊ is not a part of your medical or billing records
- ◊ is information that you are not permitted to inspect or copy
- ◊ is already a complete and accurate record

Amendment requests must be made in writing and must include a reason for requesting the amendment. If you wish to amend your record, you may contact our Privacy Officer for a form.

◊ **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**
You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than you, except for disclosures:
- ◊ to carry out treatment, payment and health care operations as described above
- ◊ to persons involved in your care or for other notification purposes as provided by law
- ◊ for national security or intelligence purposes as provided by law
- ◊ to correctional institutions or law enforcement officials as provided by law
- ◊ that occurred prior to April 14, 2003

You are allowed one free disclosure per each twelve-month period. If you wish additional disclosures within that twelve-month period, we may charge you the cost of providing the disclosure list.

Your request for a disclosure accounting must be made in writing. Please contact our Privacy Officer to obtain a form.

◊ **You have the right to file a complaint.**
If you believe that your privacy rights have been violated, you have a right to file a complaint in the form of a written letter with our office and with the Secretary of Health and Human Services without fear of retaliation.

A letter of complaint filed with this office should be sent to our Privacy Officer at the address listed below.

◊ **You have the right to request and receive a paper copy of this notice from our office.**

Revisions to Our Privacy Notice:

We are required to abide by the terms of this Privacy Notice. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. This notice is in effect as of September, 2013. Upon your request, we will provide you with a revised Privacy Notice. You may obtain this by calling our office and requesting that a revised copy be sent to you in the mail, or by asking for one at the time of your next appointment.

Questions/Contact:

If you have questions about this document, or have questions about privacy or patient rights, please contact our Privacy Officer.

Privacy Officer Name: Dr. Maryam Motlagh

Address: 13765 NW Cornell Rd. #100 Portland, OR 97229

Phone Number: 503-643-9855