HEAD, NECK AND FACIAL PAIN QUESTIONNAIRE

Form 401A

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

PATIENT INFORMATION

TODAY'S DATE _____

☐ MR. ☐ MS. ☐ MISS ☐ MRS. ☐ DR. NAME _____
First Middle Initial Last

AGE: _____ BIRTH DATE _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE _____ EMAIL: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

RESPONSIBLE PARTY: _____

FAMILY DENTIST _____

ADDRESS _____

FAMILY PHYSICIAN _____

ADDRESS _____

REFERRED BY: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please **number** your complaints with #1 being the most severe symptom, #2 the next, etc.

2. Then rate your complaints for frequency and intensity:

Frequency:
(1- SELDOM, 2-OCCASIONAL, 3- FREQUENT, 4- EVERY DAY)

Intensity:
(0 is NO PAIN and 10 is MOST SEVERE PAIN)

Number		Frequency	Intensity
#1 = the most severe symptom		**1-4**	**0-10**
____	Back Pain	____	____
____	Dizziness	____	____
____	Ear Congestion	____	____
____	Ear Pain	____	____
____	Eye Pain	____	____
____	Facial pain	____	____
____	Fatigue	____	____
____	Headaches	____	____
____	Inability to open mouth	____	____
____	Jaw Clicking	____	____
____	Jaw Joint Noises	____	____
____	Jaw Locking	____	____
____	Jaw Pain	____	____
____	Limited Mouth Opening	____	____
____	Migraine Headaches	____	____
____	Muscle Twitching	____	____
____	Neck Pain	____	____
____	Pain when Chewing	____	____
____	Ringing in the Ears	____	____
____	Shoulder Pain	____	____
____	Sinus Congestion	____	____
____	Throat Pain	____	____
____	Visual Disturbances	____	____
	Other - write in:		
____	_____	____	____
____	_____	____	____

Patient Signature

_____

Date _____

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y☐ N☐ Antibiotics
Y☐ N☐ Aspirin
Y☐ N☐ Barbiturates
Y☐ N☐ Codeine
Y☐ N☐ Iodine
Y☐ N☐ Latex
Y☐ N☐ Local anesthetics
Y☐ N☐ Metals
Y☐ N☐ Penicillin
Y☐ N☐ Plastic
Y☐ N☐ Sedatives
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs
Y☐ N☐ Other _____ _____
_____ _____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Y☐ N☐ Antibiotics
Y☐ N☐ Anticoagulants
Y☐ N☐ Barbiturates
Y☐ N☐ Blood thinners
Y☐ N☐ Codeine
Y☐ N☐ Cortisone
Y☐ N☐ Diet pills
Y☐ N☐ Heart medication
Y☐ N☐ Insulin
Y☐ N☐ Muscle relaxants
Y☐ N☐ Nerve pills
Y☐ N☐ Pain medication
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs
Y☐ N☐ Tranquilizers

Other _____ _____
_____ _____

PLEASE LIST ANY TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING:

	Practitioner	Specialty	Treatment & approximate date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

MEDICAL HISTORY (Please indicate dates on questions checked YES)

Y☐ N☐ Adenoids Removed
Y☐ N☐ Tonsils Removed
Y☐ N☐ Anemia
Y☐ N☐ Arteriosclerosis
Y☐ N☐ Asthma
Y☐ N☐ Autoimmune disorders
Y☐ N☐ Bleeding easily
Y☐ N☐ Blood pressure ☐ High ☐ Low
Y☐ N☐ Bruising easily
Y☐ N☐ Cancer
Y☐ N☐ Chemotherapy
Y☐ N☐ Chronic fatigue
Y☐ N☐ Cold hands & feet
Y☐ N☐ Current pregnancy
Y☐ N☐ Depression
Y☐ N☐ Diabetes
Y☐ N☐ Difficulty concentrating
Y☐ N☐ Dizziness
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy
Y☐ N☐ Excessive thirst
Y☐ N☐ Fluid retention
Y☐ N☐ Frequent cough
Y☐ N☐ Frequent illnesses
Y☐ N☐ Frequent stressful situations
Y☐ N☐ Fibromyalgia
Y☐ N☐ General anesthesia
Y☐ N☐ Glaucoma
Y☐ N☐ Gout
Y☐ N☐ Hay fever
Y☐ N☐ Hearing impairment
Y☐ N☐ Heart murmur
Y☐ N☐ Heart disorder
Y☐ N☐ Heart pacemaker
Y☐ N☐ Heart palpitations
Y☐ N☐ Heart valve replacement
Y☐ N☐ Hemophilia
Y☐ N☐ Hepatitis
Y☐ N☐ Hypoglycemia

Patient Signature _____ Date _____

MEDICAL HISTORY CONTINUED

Y☐ N☐ Immune system disorder
Y☐ N☐ Injury to
☐ Face ☐ Mouth
☐ Neck ☐ Teeth
Y☐ N☐ Insomnia
Y☐ N☐ Intestinal disorders
Y☐ N☐ Jaw joint surgery
Y☐ N☐ Kidney problems
Y☐ N☐ Liver disease
Y☐ N☐ Meniere's disease
Y☐ N☐ Menstrual cramps
Y☐ N☐ Multiple sclerosis
Y☐ N☐ Muscle aches
Y☐ N☐ Muscle shaking (tremors)
Y☐ N☐ Muscle spasms or cramps
Y☐ N☐ Muscular dystrophy
Y☐ N☐ Needing extra pillows to help breathing at night
Y☐ N☐ Nervous system irritability
Y☐ N☐ Nervousness
Y☐ N☐ Neuralgia
Y☐ N☐ Osteoarthritis
Y☐ N☐ Osteoporosis
Y☐ N☐ Ovarian cysts
Y☐ N☐ Parkinson's disease
Y☐ N☐ Poor circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Psychiatric care
Y☐ N☐ Radiation treatment
Y☐ N☐ Rheumatic fever
Y☐ N☐ Rheumatoid arthritis
Y☐ N☐ Scarlet fever
Y☐ N☐ Shortness of breath
Y☐ N☐ Sinus problems
Y☐ N☐ Skin disorder
Y☐ N☐ Slow healing sores
Y☐ N☐ Speech difficulties
Y☐ N☐ Stroke
Y☐ N☐ Swollen, stiff or painful joints
Y☐ N☐ Tendency for:
☐ Frequent Colds
☐ Ear Infections
☐ Sore Throats
Y☐ N☐ Tired muscles
Y☐ N☐ Tuberculosis
Y☐ N☐ Tumors
Y☐ N☐ Urinary disorders
Y☐ N☐ Wisdom teeth (Third Molar) extraction

Other _____

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

L= Left R=Right B=Both sides

HEAD PAIN LOCATION	SEVERITY			FREQUENCY			DURATION				
	MILD	MODERATE	SEVERE	OCCASIONAL (MONTHLY OR LESS}	FREQUENT (WEEKLY)	CONSTANT (EVERY DAY)	SECONDS	MINUTES	HOURS	DAYS	WEEKS
L R B Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Top of your head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

JAW PAIN

L R B Jaw pain - on opening
L R B Jaw pain - while chewing
L R B Jaw pain - at rest

JAW SYMPTOMS

Y☐ N☐ Jaw clicks
Y☐ N☐ Jaw locks closed
Y☐ N☐ Jaw locks open
Y☐ N☐ Jaw popping
Y☐ N☐ Teeth clenching
Y☐ N☐ Teeth grinding

EYE RELATED CONDITIONS

Y☐ N☐ Blurred vision
Y☐ N☐ Double vision
Y☐ N☐ Eye pain
Y☐ N☐ Pain or pressure behind the eyes
Y☐ N☐ Photophobia (extreme sensitivity to light)

EAR RELATED CONDITIONS

Y☐ N☐ Buzzing in the ears
Y☐ N☐ Ear congestion
Y☐ N☐ Ear pain
Y☐ N☐ Hearing loss
Y☐ N☐ Pain behind the ear
Y☐ N☐ Pain in front of the ear
Y☐ N☐ Recurrent ear infections
Y☐ N☐ Tinnitus (ringing in the ear)

THROAT NECK & BACK RELATED CONDITIONS

Y☐ N☐ Back pain - lower
Y☐ N☐ Back pain - middle
Y☐ N☐ Back pain - upper
Y☐ N☐ Chronic sore throat
Y☐ N☐ Constant feeling of a foreign object in throat
Y☐ N☐ Difficulty in swallowing
Y☐ N☐ Limited movement of neck
Y☐ N☐ Neck pain
Y☐ N☐ Numbness in the hands or fingers

Patient Signature _____ Date _____

THROAT NECK & BACK RELATED CONDITIONS (Continued)

- Y☐ N☐ Sciatica
- Y☐ N☐ Scoliosis
- Y☐ N☐ Shoulder pain
- Y☐ N☐ Shoulder stiffness
- Y☐ N☐ Swelling in the neck
- Y☐ N☐ Swollen glands
- Y☐ N☐ Thyroid enlargement
- Y☐ N☐ Tightness in throat
- Y☐ N☐ Tingling in the hands or fingers
- Y☐ N☐ Wryneck

MOUTH & NOSE RELATED CONDITIONS

- Y☐ N☐ Broken teeth
- Y☐ N☐ Burning tongue
- Y☐ N☐ Chronic sinusitis
- Y☐ N☐ Dry mouth
- Y☐ N☐ Frequent biting of cheek
- Y☐ N☐ Frequent snoring

Other _____

HISTORY OF SYMPTOMS

When did your condition first occur? _____

_____

What do you believe is the cause of your pain or condition?

Pick one:

☐ Motor vehicle accident ☐ Motorcycle accident ☐ Work related incident ☐ Playground incident
☐ Athletic endeavor ☐ Fight ☐ Fall ☐ Accident ☐ Illness ☐ Injury
☐ Unknown ☐ Other _____

If accident, date _____

Is there anything that makes your pain or discomfort worse? _____

Is there anything that makes your pain or discomfort better? _____

What other information is important to your pain or condition? _____

_____

FAMILY HISTORY

Have any members of your family (blood kin) had:

- Y☐ N☐ Headaches
- Y☐ N☐ High blood pressure
- Y☐ N☐ Heart disease
- Y☐ N☐ Diabetes

SOCIAL HISTORY

Occupation _____

Do you have children? Y☐ N☐ If yes, how many children? _____ What are their ages? _____

- Y☐ N☐ Are you currently under unusual stress?
- Y☐ N☐ Recent change in lifestyle?
- Y☐ N☐ Do you exercise regularly?
- Y☐ N☐ Do you chew tobacco?

Number of caffeine drinks per day _____

Y☐ N☐ Do you smoke?

_____ *Number of* ☐ Packs ☐ Cigarettes *per* ☐ Day ☐ Week

Alcohol consumption

☐ None ☐ Occasional ☐ Social Drinker ☐ Daily

Patient Signature _____ Date _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

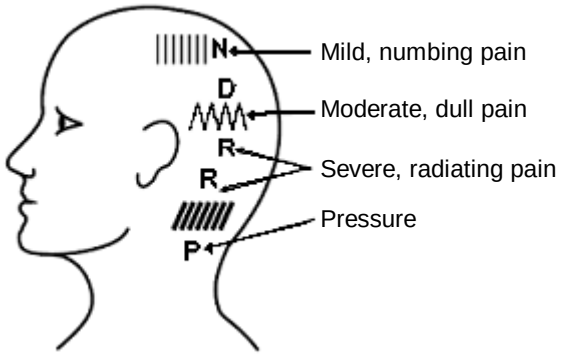
MILD PAIN

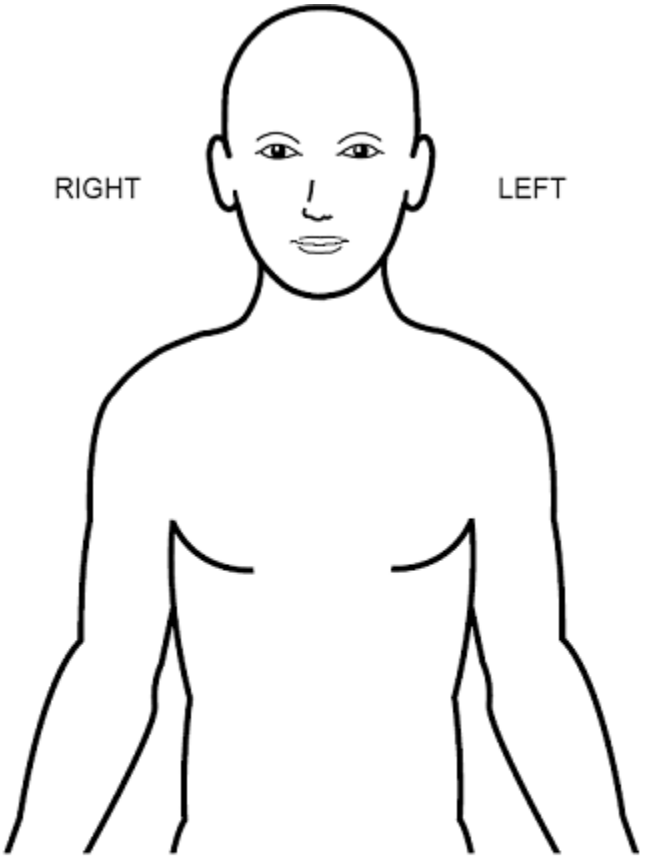
MODERATE PAIN

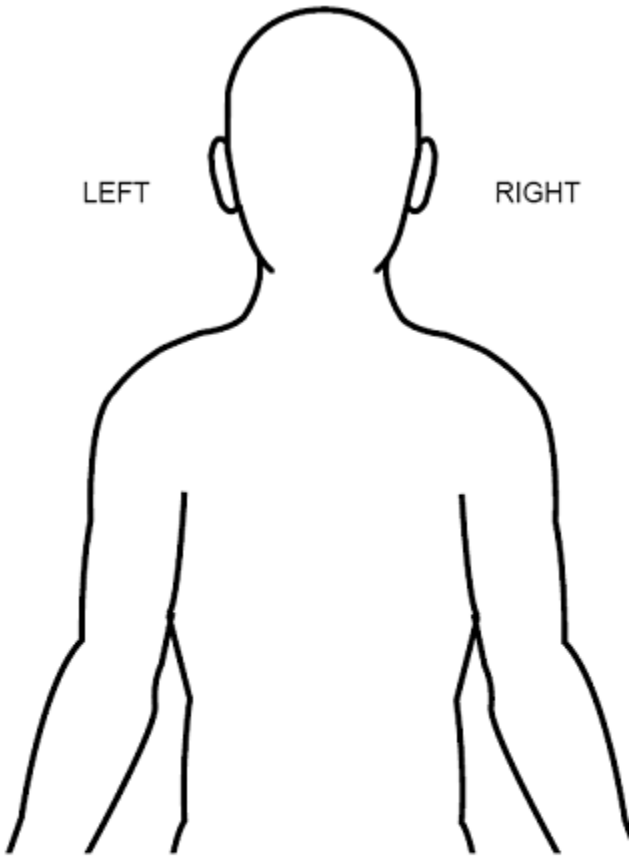
SEVERE PAIN

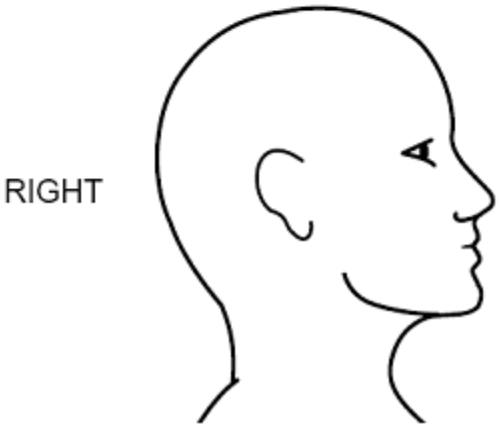
B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating

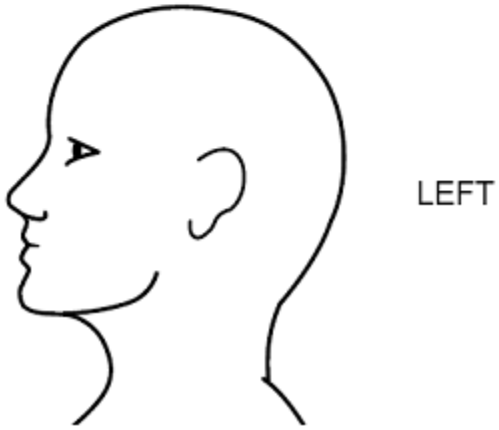
EXAMPLE











Patient Signature _____ Date _____

HISTORY OF ACCIDENT

IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT, COMPLETE THIS SECTION.

DATE OF ACCIDENT OR INCIDENT _____

WERE YOU ? (Choose one)

- ☐ A passenger in a vehicle
- ☐ The driver of a vehicle
- ☐ A pedestrian
- ☐ At work

AND... (Choose one)

- ☐ Did you fall?
- ☐ Were you hit by an object?
- ☐ Did you hit an object?
- ☐ Other _____

IF IN A VEHICLE WHERE WAS THE VEHICLE HIT?

- ☐ At front end
- ☐ At rear end
- ☐ At front right area
- ☐ At front left area
- ☐ At rear right area
- ☐ At rear left area
- ☐ Head on
- ☐ On driver's side
- ☐ On passenger's side
- ☐ Other _____

INDICATE IF THERE WAS ANY DIRECT TRAUMA.

DID YOUR

- ☐ Forehead
- ☐ Face
- ☐ Chin
- ☐ Side of head
- ☐ Back of head
- ☐ Top of head
- ☐ Teeth
- ☐ Jaw
- ☐ Other _____

FORCIBLY STRIKE

- ☐ Steering wheel
- ☐ Windshield
- ☐ Passenger's side window
- ☐ Driver's side window
- ☐ Passenger's side door
- ☐ Driver's side door
- ☐ Headrest
- ☐ Seat
- ☐ Roof
- ☐ Interior of car
- ☐ Other _____

WERE ANY AREAS OF YOUR BODY PAINFUL SHORTLY AFTER THE ACCIDENT/INCIDENT?

- ☐ Head
- ☐ Neck
- ☐ Face
- ☐ Jaw
- ☐ Left shoulder
- ☐ Right shoulder
- ☐ Left arm
- ☐ Right arm
- ☐ Lower back
- ☐ Upper back
- ☐ Other: _____

BRIEFLY DESCRIBE THE HISTORY OF SYMPTOMS, ACCIDENT OR INCIDENT: _____

_____

_____

DID YOU GO TO THE HOSPITAL? ☐ Yes ☐ No ☐ By Car ☐ By Ambulance

☐ TAKEN TO THE HOSPITAL FOR X-RAYS & EVALUATION

WERE YOU ☐ SUBSEQUENTLY RELEASED ON (Date) _____

WHICH HOSPITAL? _____

HAD A DOCTOR OR DENTIST EVER DIAGNOSED A TMJ DISORDER PRIOR TO THE ACCIDENT?

☐ Yes ☐ No If yes, please explain _____

_____

Patient Signature _____ Date _____

IF YOU HAD A PREVIOUS ACCIDENT, PLEASE GIVE AN ACCURATE DESCRIPTION, _____

_____

_____ INCLUDING DATE: _____

NAMES AND ADDRESSES OF HOSPITALS AND DOCTORS WHERE TREATED FOR THIS PREVIOUS ACCIDENT: _____

_____

_____

IF YOU HAVE MISSED ANY WORK PLEASE GIVE DATES: _____

_____

INSURANCE INFORMATION

AUTO INSURANCE

Please mark each insurance category

☐ your insurance ☐ driver of vehicle's insurance ☐ other vehicle's insurance ☐ owner of vehicle's insurance

Insured _____ Insured's Soc. Sec. No. _____

Relationship _____

Insured's Address _____

City, State, Zip _____

Insurance Co. _____ Adjuster (not agent) _____ Phone No. _____

Insurance Billing Address _____

City, State, Zip _____

Policy No. _____ Claim No. _____ Has this been reported? ☐ Yes ☐ No

OTHER TYPES OF INSURANCE

HEALTH INSURANCE (Complete even if you are covered by auto insurance)

Insured _____ Insured's Soc. Sec. No. _____

Relationship _____

Insured's Address _____

City, State, Zip _____

Insurance Co. _____ Adjuster (not agent) _____ Phone No. _____

Insurance Billing Address _____

City, State, Zip _____

Policy No. _____ Group No. _____ I.D. No _____

WORKER'S COMPENSATION

Employee _____

Address _____

City, State, Zip _____

Employer _____ Phone No. _____ Supervisor _____

Has this been reported? ☐ Yes ☐ No If yes, was treatment authorized? _____

Insurance Co. _____

Insurance Billing Address _____

City, State, Zip _____

Policy No _____ Group No. _____ I.D. No. _____

If you have additional insurance, please enter the information on the reverse side of this form.

Patient Signature _____ Date _____

ATTORNEY INFORMATION

If you have an attorney representing you, please complete the following:

Attorney's Name _____ Paralegal _____ Phone No. _____

Address _____

City, State, Zip _____

Are you involved in a lawsuit regarding your condition? ☐ Yes ☐ No

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature _____ Date _____

FOR OFFICE USE ONLY

Insurance Company _____

☐ Group Health ☐ Auto ☐ Government ☐ Self Insured ☐ Dental

Contact Person _____

Effective date of this policy _____ TMJ policy exclusions _____

Amount of deductible? _____ Has it been satisfied? _____

At what percentage are benefits paid? _____

Is there a policy maximum for TMJ disorders? _____

Is precertification required _____

Can benefits be assigned to doctor? ☐ Yes ☐ No

What information is needed to process the claim? _____

_____

_____

For No Fault: Amount of benefits _____

Mailing Address _____

City, State, Zip _____

Adjuster _____ Assignment approved ☐ Yes ☐ No

By _____

Other: _____

_____

_____

_____

Patient Signature _____ Date _____

NAME: _____ **DATE:**_____

Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	0	1	2	3
Sitting and reading				
Watching TV				
Sitting inactive in a public place (theatre, meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				

Total: _____

Screening Tool for Sleep Apnea - Developed by David White, M.D., Harvard Medical School, Boston, MA

1. Snoring

a). Do you snore on most nights (> 3 nights per week)?

Yes (2) No (0) _____

b). Is your snoring loud? Can it be heard through a door or wall?

Yes (2) No (0) _____

2. Has it ever been reported to you that you stop breathing or gasp during sleep?

Never (0) Occasionally (3) Frequently (5) _____

3. What is your collar size?

Male: Less than 17 inches (0) more than 17 inches (5) _____

Female: Less than 16 inches (0) more than 16 inches (5) _____

4. Do you occasionally fall asleep during the day when:

a). You are busy or active?

Yes (2) No (0) _____

b). You are driving or stopped at a light?

Yes (2) No (0) _____

5). Have you had or are you being treated for high blood pressure?

Yes (1) No (0) _____

TOTAL: _____

Score: 9 points or more – refer to sleep specialist or order sleep study
6-8 points – gray area use clinical judgement
5 points or less – low probability of sleep apnea

Please list any treatments you have had for this problem and all health professionals that you are currently seeing:

1.

Practitioner Name: _____ **Specialty:** _____

Practitioner Address: _____

Practitioner Phone: _____ **Approximate Treatment Date:** _____

Treatment: _____

3.

Practitioner Name: _____ **Specialty:** _____

Practitioner Address: _____

Practitioner Phone: _____ **Approximate Treatment Date:** _____

Treatment: _____

3.

Practitioner Name: _____ **Specialty:** _____

Practitioner Address: _____

Practitioner Phone: _____ **Approximate Treatment Date:** _____

Treatment: _____

4.

Practitioner Name: _____ **Specialty:** _____

Practitioner Address: _____

Practitioner Phone: _____ **Approximate Treatment Date:** _____

Treatment: _____

5.

Practitioner Name: _____ **Specialty:** _____

Practitioner Address: _____

Practitioner Phone: _____ **Approximate Treatment Date:** _____

Treatment: _____

Center for TMJ Therapy
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Social Security Number: _____

Address: _____

Telephone: _____ E-mail: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Alpharetta office manager phone (770) 521 1978 fax (770) 521 9936 or 3590 Old Milton Parkway, Alpharetta, GA 30005

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Center for TMJ Therapy

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 (01/01/2014), 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 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 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 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.

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 $3.00 for each page, $20 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.

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.

Alpharetta Office 3590 Old Milton Parkway, Alpharetta, GA 30005

Phone (770) 521-1978 Fax (770) 521-9936

E-Mail: office@tmdatlanta.com

INSURANCE POLICY

The Center for TMJ Therapy does not file or accept assignment from medical insurance companies, due to many reasons such as: inconsistencies in benefit information, extreme delays in payment, multiple denials of a claim for no legitimate reasons, do not pay directly to our office since we are not a network provider.

We need to inform you that you are entering into a relationship with the doctor in which the doctor agrees to treat the patient and the patient agrees to pay the doctor's fees for that treatment. The insurance company has ***NO*** relationship with the doctor.

As a courtesy to you, we will prepare two copies of a "Doctor's Statement of Services" and any supporting documentation that we feel the insurance company may need for each visit with us for which there is a charge. You will then fill out the employees portion on your insurance carriers medical claim form and attach the "Doctor's Statement of Services" and any other documentation to your form and send it to your insurance company for them to send any benefits to you. Always keep one copy for your records.

Any additional information needed to process your claims will be provided upon request from the insurance company.

We suggest to all patients that they contact their insurance company to find out their TMJ benefits, policies and limitations. Remember, insurance companies give estimates and benefits over the phone, however they are ***ONLY*** estimates and are not always accurate or a guarantee of reimbursement.

FINANCIAL POLICY

Fees are paid as services are rendered. We accept all major credit cards, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS and or CASH.

Payment plans for the estimated treatment may be made with Care Credit Services upon prior approval of your credit application. Several payment options, ***(with and without interest)*** are offered.

I will pay for services rendered on the date of service. I acknowledge that I have read this form and that I fully understand its contents that I have been given ample opportunity to ask questions and that all questions have been answered satisfactorily.

THIS IS NOT A CONTRACT NOR AN AGREEMENT TO SEEK TREATMENT

Signature of patient _____ Date _____
(Parent or guardian)

Signature of doctor's representative _____