ROYA E. LEVI, DDS
MAIN STREET DENTISTRY

2409 Main Street Suite B Santa Monica, CA 90405
Office Phone: (310) 392-8313 Fax #: (310) 581-0716
Email: drroyalevi@mainstdds.com
www.mainstdds.com

Dear New Patient:

Welcome to Main Street Dentistry! Thank you for allowing us to serve your oral health needs. Dr. Roya Levi is a well-known dentist in the Santa Monica, California area. At Main Street Dentistry, she offers several services to her patients, including:

- Crowns and bridges
- Teeth cleanings/ preventive checkups
- Dental Implants
- Invisalign
- Root canal therapy
- Tooth pain, TMJ treatment
- Dental emergencies
- Veneers
- Teeth whitening procedures

Dr. Levi provides her patients with a level of care that is second to none. She is expertly trained in complex and cosmetic dental procedures and follows the latest advancements in dentistry.

In addition to the services listed above, she also offers 24/7 dental emergency service to ensure her patients in the Santa Monica and greater Los Angeles area to get the dental care they need.

Dr. Levi graduated in 1991 from the University of California, Los Angeles (UCLA) School of Dentistry. She received degrees in both dentistry and dental surgery. As a licensed medical professional, she continues her education on a regular basis so she can offer each patient the latest in technologically advanced treatments. One of her goals is to provide the highest level of dental care possible to as many patients as possible. Outside of the dental office, Dr. Levi is a mother of a wonderful set of triplets, two girls and one boy, and enjoys spending quality time with her family.

PATIENT INFORMATION SHEET

Name (First, Last) _____ Date _____

Date of Birth _____

Home Address_____ City _____ State _____

Zip Code _____

Email address _____ Cell Phone _____

Home Phone _____ Work Phone _____

Social Security No. _____ Driver's License No. _____

Are you a minor, parent, or Legal Guardian? _____

Occupation _____

Patient's Employer _____ Length of Employment _____

Employer's Address _____

Name of Spouse _____

Spouse's Employer _____

Person responsible for this account _____

Billing Address _____

Do you have Dental insurance? Yes ❑ No ❑

Name of Dental Insurance Carrier_____

Address of Dental Insurance Carrier _____

A person NOT living with you who could be reached in case of an emergency:

Name _____ Cell Phone _____

Home Phone _____ Work Phone _____

Home Address_____

Whom may we thank for referring you? _____

Insurance Information

If you do not have dental insurance please inform us. If you do have dental insurance please fill out the information below so we can verify your insurance information (our office email address and your information is confidential and HIPPA compliment).

Patient's Information:

Patient's Name (First, Last): _____

Patient's Date of Birth: _____

Patient's Social Security #: _____

Patient's Employer: _____

Relationship to Subscriber:_____

Subscriber's ID #:_____

Are you the subscriber? Yes:_____ No:_____
If no, fill out below please.

Subscriber's Information:

Subscriber's Name (First, Last):_____

Subscriber's Date of Birth: _____

Subscriber's Social Security #: _____

Subscriber's ID #:_____

Attach a photo of the front and back of your dental insurance card and fill out below please:

Dental Insurance Name: _____

Dental Insurance Phone #: _____

Group/ID #:_____

During your first visit typically x-rays are taken, an examination with Dr. Levi, and a dental cleaning is performed. If it has been over a year since you have take x-rays we will take new ones, if it has been less than a year since you have taken x-rays we can accept those as your current x-rays. We can contact your previous dentist regarding your x-rays or **for more efficient and faster results you can contact your previous dentist to email the x-rays to us prior to your appointment. Previous dentists tend to release information faster to you than to us, so we strongly recommend you to contact your previous dentist regarding x-rays.**

Date of last x-rays taken:_____

If you want us to contact the your previous dentist, there is a release form at the very end of this packet giving us permission to contact your previous dentist to obtain oral information such as x-rays.

Office Hours:

Monday 8:30 am - 5:30 pm
Tuesday 8:30 am - 5:30 pm
Wednesday- Closed
Thursday 8:30 am - 5:30 pm
Friday 8:30 am - 5:30 pm
Saturday-Select Saturdays
Sunday-Closed

MAP

PARKING

There is an outdoor metered Public Parking lot up to 6 hours on Main Street right before the restaurant called “The Galley” on the opposite side of the street from our dental office, and also there is meter parking on the street.

WHAT TO EXPECT AT THE FIRST VISIT?

For the first visit at Main Street Dentistry: The dental assistant will take digital X-rays with minimal radiation, then Dr. Levi will come and talk to you regarding your oral hygiene and go from there.

HOW ARE EMERGENCIES HANDLED?

In case of an emergency that does not involve 911, Dr. Levi will immediately refer you to a Doctor in close proximity and provide you the address.

Smile Evaluation

With recent advancements in materials and techniques, many of our patients are inquiring about cosmetic dental procedures. In order to better serve you, please take a moment to let us know how you feel about the appearance of your smile.

Name _____ Date _____

Do you like the appearance of your teeth? Yes ❑ No ❑

Are your teeth as straight as you would like them to be? Yes ❑ No ❑

Are you happy with the length, width, and shape of your teeth? Yes ❑ No ❑

Do you think you have a "gummy" smile? Yes ❑ No ❑

Do you have any chipped teeth? Yes ❑ No ❑

Do you have any missing teeth? Yes ❑ No ❑

Do you have any spaces between your teeth? Yes ❑ No ❑

Do you have any discolorations, stains or spots on your teeth? Yes ❑ No ❑

Would you like for your teeth to be whiter? Yes ❑ No ❑

Do you have any dental work that you do not like? Yes ❑ No ❑

Do you have any silver fillings that you would like changed to white? Yes ❑ No ❑

Do you know anyone that has any cosmetic dentistry that interests you? Yes ❑ No ❑

From the above questions, which concerns you the most?

_____

_____

_____

_____

If you could change anything about the appearance of your teeth, what would it be?

_____

_____

_____

_____

DENTAL HISTORY

Have you had orthodontic treatment? Yes ❑ No ❑
If yes, when? _____

Do you have un-replaced missing teeth? Yes ❑ No ❑

Do your gums bleed when brushing your teeth? Yes ❑ No ❑

Is any part of your mouth sensitive to temperature or pressure? Yes ❑ No ❑
If yes, what part? _____

Do you have any unpleasant odor or taste in your mouth? Yes ❑ No ❑

Does food catch between your teeth? Yes ❑ No ❑
If yes, where? _____

Are you dissatisfied with your teeth and their appearance? Yes ❑ No ❑

Do you clench or grind your teeth during the day? Yes ❑ No ❑

Have you been made aware of clenching/grinding your teeth during the night? Yes ❑ No ❑

Do you have chronic headaches or neck and shoulder pains? Yes ❑ No ❑

Do you have headaches when you wake up? Yes ❑ No ❑

Do you ever wake up with awareness of or about your teeth or jaw like you've had them clenched in your sleep? Yes ❑ No ❑

Do you have any awareness of discomfort in the muscles of your neck or shoulders? Yes ❑ No ❑

Has your jaw ever locked? Yes ❑ No ❑

Do you now or have you ever had pain in your jaw joint or the sides of your face (in & about the ears)? Yes ❑ No ❑

Have you been diagnosed as having migraine headaches? Yes ❑ No ❑

Do you have a clicking jaw joint or have you ever experienced the inability to move your jaw or open your mouth wide? Yes ❑ No ❑

Which side do you chew on? Right _____ Left_____ Both_____

Have you ever had a bite split or a night guard? Yes ❑ No ❑
If yes, do you wear one now? Yes ❑ No ❑

Do you have any dental complaints not specifically covered above? Yes ❑ No ❑

I, _____, have completed this pre-clinical examination questionnaire to the best of my knowledge.

Signature: _____ Date: _____

Reviewed by Dr. Levi: _____ Date: _____

Office Policies

Financial Policy

Thank you for selecting us as your dental care provider. We are committed to helping you with the highest level of quality, preventive care. Payment for services rendered is part of your treatment. Outlined below is our financial policy. Please read it carefully and sign it before being seen by the doctor.

1. Full payment is due at the time of service unless previous arrangements have been made.

2. We accept cash, checks, Visa/Mastercard, American Express, and Discover.

3. If you have a dental benefit/insurance plan, you are expected to pay your estimated portion of the

total fee (co-pays, or deductible) at the time of service.

4. With prior arrangements, we offer an extended payment plan through an outside financing company.

We are committed to providing the best treatment options based on a diagnosis of what is needed to save and prevent further loss or damage to your gums and teeth.

If we are provided with all the necessary information, we will accept assignment of your dental insurance benefit. This information must be provided before treatment begins. You will be expected to pay your estimated portion of the fee for treatment. There are insurance rules and restrictions that limit the information we can obtain about your plan. We can only provide you with an estimate. The actual amount is likely to be different, all depending on what your insurance will cover or unexpected changes in treatment.

Regardless of any insurance company's arbitrary determination of what is usual and customary, we charge fees that are usual and customary for our area. Our fees are based on the quality of our materials and equipment, the expertise of doctor, and the level of service that goes into your dental experience. Our diagnosis will not be based on what your insurance company will cover, the amount of money you have left on your deductible, or how economical the treatment will be. Again, it will be based on what is in the best interest of your dental and health care. Your insurance policy is a contract between you or your employer, and the insurance company. We are not a party to that agreement. Until your insurance company has paid their portion of services rendered, the unpaid balance may appear on your monthly statement. If your insurance company has not paid on claims submitted within 60 days, you will be responsible for the entire balance for services that have been provided.

If financial arrangements are made to include a payment plan, we expect you to adhere to this agreement strictly. A 11-12% finance charge (18% annually) will be added to any balance that is more than 60 days overdue. To prevent finance or re-billing charges, we ask that you comply with your original financial arrangement. This will eliminate all of the extra time for processing and the embarrassment or awkwardness of collecting on treatment that has been provided. If your account becomes delinquent for more than 60 days and you are in need of additional treatment, full payment must be made prior to the time of service.

Appointment Policy

We make every attempt to schedule appointments for our patients in a manner that reduces any waiting time and provide prompt and attentive service to each and every patient. We do not double book appointments and make every effort to be ready for you at your scheduled appointment time. We expect our patients to respect their scheduled appointment times and make every effort to be as on time for us as we are for you.

We require 48-hour notice for any appointment change. Failure to do so could result in a broken appointment charge. A broken appointment is a loss to you and prevents us from providing you with needed preventive and restorative care. It is a loss to the patient who could have had that appointment time, and it is a loss to our team who was fully prepared for your visit. Keeping your scheduled appointments and being on time is an important part of what contributes to our team providing the care our patients are accustomed to. We realize changes may need to be made occasionally, but we respectfully ask for your attention to this matter. Longer surgical & specialty procedures may require an initial payment to reserve appointment times.

Patient _____ Date _____

Parent or Guardian_____ Relationship _____

Confidential Patient Medical History

Patient's Name:_____Date of Birth: _____

Medical Doctor's Name _____ Phone _____

Address _____

Have you been seen by your medical doctor during the past year? Yes ❑ No ❑

Have you ever been **hospitalized?** Yes ❑ No ❑
If yes, for what? _____

Have you ever had **surgery?** Yes ❑ No ❑
If yes, for what? _____

Have you ever had any serious accidents involving **head injuries?** Yes ❑ No ❑

Do you smoke? Yes ❑ No ❑

Do you use smokeless tobacco? Yes ❑ No ❑

Are you **allergic** to any drugs or medications? Yes ❑ No ❑
If yes, please list them _____

Have you taken tamoxifen? Yes ❑ No ❑
If yes, when? _____

Are you taking tamoxifen? Yes ❑ No ❑

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes/No Is your general health good?
   If NO, explain: _____
2. Yes/No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes/No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes/No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam?_____Reason for exam: _____
5. Yes /No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam:_____Name of last treating dentist: _____
6. Yes/No Are you in pain now?
   If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes/No	Chest pain	Yes/No	Blood in stools	Yes/No	Vomiting
Yes/No	(angina) Fainting	Yes/No	Diarrhea or constipation	Yes/No	Jaundice
Yes/No	Recent weight loss	Yes/No	Frequent urination	Yes/No	Dry mouth
Yes/No	Fever	Yes/No	Difficulty urinating	Yes/No	Excessive thirst
Yes/No	Night sweats	Yes/No	Ringing in ears	Yes/No	Difficulty swallowing
Yes/No	Persistent cough	Yes/No	Headaches	Yes/No	Swollen ankles
Yes/No	Coughing up blood	Yes/No	Dizziness	Yes/No	Joint pain or
Yes/No	Bleeding problems	Yes/No	Blurred vision	Yes/No	Shortness of breath
Yes/No	Blood in urine	Yes/No	Bruise easily	Yes/No	Sinus problems

Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes/No	Heart disease	Yes/No	AIDS/HIV	Yes/No	Psychiatric care

Yes/No	Family history of heart	Yes/No	Surgeries	Yes/No	Osteoporosis
Yes/No	Heart attack	Yes/No	Hospitalization	Yes/No	Thyroid disease
Yes/No	Artificial joint	Yes/No	Diabetes	Yes/No	Asthma
Yes/No	Stomach problems or ulcers	Yes/No	Family history of diabetes	Yes/No	Hepatitis
Yes/No	Heart defects	Yes/No	Tumors or cancer	Yes/No	Sexual transmitted
Yes/No	Heart murmurs	Yes/No	Chemotherapy	Yes/No	Herpes
Yes/No	Rheumatic fever	Yes/No	Radiation	Yes/No	Canker or cold sores
Yes/No	Skin disease	Yes/No	Arthritis/rheumatism	Yes/No	Anemia
Yes/No	Hardening of arteries	Yes/No	Emphysema or other lung	Yes/No	Liver disease
Yes/No	High/Low blood pressure	Yes/No	Kidney or bladder disease	Yes/No	Eye disease
Yes/No	Seizures	Yes/No	Stroke	Yes/No	Transplants
Yes/No	Cosmetic surgery	Yes/No	Eating disorders	Yes/No	Tuberculosis
Yes/No	Pacemaker	Yes/No	Blood Transfusion	Yes/No	Fainting spells

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?
(Please circle Yes or No for each)

Yes /No	Aspirin	Yes/No	Valium or other sedatives	Yes/No	Codeine or othnarcotics
Yes/ No	Penicillin or other	Yes/No	Latex	Yes/No	Food
Yes/ No	Nitrous oxide	Yes/No	Local anesthetic	Yes/No	Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?
(Please circle Yes or No for each)

Yes/No	Recreational drugs	Yes/No	Tobacco in any form	Yes/No	Antibiotics
Yes/No	Over-the-counter medicines	Yes/No	Alcohol	Yes/No	Supplements
Yes/No	Weight loss medications	Yes/No	Bisphosphonate (Fosamax)	Yes/No	Aspirin
Yes/No	Anti-Depressants	Yes/No	Herbal Supplements		

Please list all prescription medications: _____

VI. **WOMEN ONLY** (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VII. **ALL PATIENTS** (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature:_____ Date: _____

Physician's Name:_____ Phone Number: _____

Whom would you like us to contact in case of an emergency?

Name: _____ **Relationship:** _____ **Phone Number:** _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

Consent Form for Use or Disclosure of Patient Health Information

Instructions: *Please complete and provide to the above dental practice. You may request a copy of this completed form. For questions, ask to speak with the dental practice's privacy officer.*

I authorize Main Street Dentistry to use or to disclose to [Recipient's Name] the health information of [Patient's Name] for the purpose of [Description of the Purpose of the Release]. I understand the receiving party may not further disclose this health information without first obtaining a new written authorization from me. I understand this authorization may be cancelled or modified at any time upon provision of a written notice to this dental practice. I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits. I understand I may have a copy of this authorization.

The health information to be used or disclosed is limited to the following: *(you may note dates, procedures, or use other description)*

_____

_____

This authorization is valid until [Date or event]: _____

_____

Signature: _____

Print name: _____

Date Signed: _____

Signed by: □ Patient □ Parent/legal guardian
□ Personal representative of the patient -- *describe the legal authority that permits the representation:*

_____

Extra Information regarding HIPAA Facts

Notice of Privacy Practices

This Notice describes how your health information 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

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect _____[date], 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 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. For more information about our privacy practices or additional copies of this Notice, please contact us (contact information below).

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations.

For example:

Treatment:

We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment:

We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Healthcare Operations:

We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, 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 is 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. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Unsecured Email:

We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

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 may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without you written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership:
If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Required by Law:
We may use or disclose your health information when we are required to do so by law.

Public Health:
We may, and are sometimes legally obligated, to disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders:
We may contact you to provide you with appointment reminders via voicemail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

Sign In Sheet and Announcement:
Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

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 contacting our office. 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. If you request copies, there may be a charge for time spent. If you request an alternate 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 for a full explanation of our fee structure.

Disclosure Accounting:
You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. 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 emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

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 of how payments will be handled under the alternative means or location you request.

Breach Notification:
In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

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.

Questions and Complaints:
If you want more information about our privacy practices or have questions or concerns, please contact us at:

Telephone: (310) 392-8313

Fax: (310) 581-0716

E-mail: drroyalevi@mainstdds.com

Address: 2409 Main Street Suite B Santa Monica, CA 90405

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 send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of the _____ [name of practice] Notice of Privacy Practices.

_____[Please Print Name]

_____[Signature]

_____[Date]

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

Personal Representative's name

Relationship to Patient _____

RELEASE FORM

Roya Elyaszadeh Levi, DDS
2409 Main Street Suite B
Santa Monica, CA 90405
Office #: (310) 392-8313 Fax #: (310) 581-0716
Email: drroyalevi@mainstdds.com
www.mainstdds.com

I hereby authorize Dr. Roya E. Levi, DDS, to release to _____
x-rays and oral information which pertains to my assessment and treatment.

My signature below acknowledges my understanding, authorization, and consent for the following:

a. The release of patient information authorization is valid for 1 year.
b. This authorization covers both the release of that information specified above presently compiled and information to be compiled during the course of treatment.
c. This authorization is subject to my revocation at any time except for information already released.

Patient's Name _____

Patient's Signature _____ Date _____