ALEX DRAKE, DDS, PA
1215 SE Industry Dr.
Oxford, North Carolina 27565

919-693-9555 • FAX 919-693-9559 • myoxforddentist.com • Email: info@myoxforddentist.com

We welcome you to Drake Dentistry and thank you for allowing us to provide your dental care! Please take the time to completely fill out both sides of this confidential information form so that we can better serve you.If you have any questions, do not hesitate asking!

Patient Information (Confidential)

Name _____ Birthdate _____ SS# _____
FIRST MI LAST

Physical Address _____ City, State _____ Zip Code _____

Mailing Address _____ City, State _____ Zip Code _____
(if different from above)

Home Phone (___) _____ Cell Phone (___) _____ Marital Status: M S D W

Employer _____ Work Phone (___) _____

Spouse's Name _____ Employer _____ Work Phone (___) _____

Father's Name _____ Employer _____ Work Phone (___) _____
(if patient is under 18 and/or a student)

Mother's Name _____ Employer _____ Work Phone (___) _____
(if patient is under 18 and/or a student)

Contact Person _____ Relationship _____ Day Phone (___) _____
(not living in your household)

Hobbies/Interests _____

Whom May We Thank For Referring You To Us? _____ Relationship _____

Person Responsible for Account (if different from patient)

Name _____ Relationship to patient _____ Birthdate _____

Physical Address _____ City, State _____ Zip Code _____

Mailing Address _____ City, State _____ Zip Code _____
(if different from above)

SS# _____ Home Phone (___) _____ Cell Phone (___) _____

Employer _____ Work Phone (___) _____

Is this person currently a patient in our office? Yes No

Dental Insurance Coverage

Name of Policy Holder/Employee _____

Policy Holder's Social Security Number _____

Policy Holder's Date of Birth _____

Policy Holder's Employer _____

Insurance Company Name _____

Group Policy Number _____

Insurance Company's Telephone Number (____) _____

Insurance Company's Mailing Address for Dental Claims _____

_____

_____

I hereby certify that I have read and understand the information to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize radiographs (X-rays), study models and photographs, diagnostic casts or any other diagnostic aids deemed appropriate by the doctor to make a thorough examination. I authorize the doctor to perform dental treatment that we have mutually agreed upon and to employ assistance as required providing proper care. I consent to the use of appropriate medications and therapy as deemed necessary. I fully understand that the use of anesthetic agents embodies a certain risk, which may include parasthesia or other injury.

I hereby give the absolute right and permission to use my audio/visual materials, including photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said materials.

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my dependents or me during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. In compliance with the Truth in Lending law, I agree to be financially responsible for payment of all services rendered on my behalf and/or my dependents. **I understand that payment is due at the time of service unless other arrangements have been made prior to treatment.** If I do not pay in full at the time of service, I understand that I will be charged 18% APR on the balance due after 60 days, and after that 60 days if the balance is unpaid, I understand that other collection procedures will be exercised and I will be responsible for all expenses incurred regarding collection of my account.

X _____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN | RELATIONSHIP TO PATIENT

_____ _____

DATE | OFFICE STAFF WITNESS

(Please see other side also)

DENTAL HISTORY

Patient Name	Medical Alert
I prefer to be called (nickname)	Premedication

We are pleased to welcome you to our practice. We are concerned about you and are eager to provide the best care possible. To help us evaluate your desires, concerns and health, please fill out **BOTH** sides of this form. If you are unsure of a question or don't understand, please ask us. All information is completely confidential.

What is the reason for your visit today? _____

What is your main dental concern?
- ❑ overall good health and dental health maintenance
- ❑ taking care of current problem only

Please enter dates of your last.....

Dental Visit:	Cleaning:	Full mouth X-ray:

What was done at your last visit? _____

Previous dentist's name & location: _____

If patient is a child, do you anticipate any behavior problems or difficulties? _____

Would you like your smile to be better, brighter, or different? _____

Are any of your teeth sensitive to:	
Hot or Cold?	**YES NO**
Sweets?	**YES NO**
Biting or chewing?	**YES NO**
Have you noticed any bad odors or tastes?	**YES NO**
Do your gums bleed or hurt?	**YES NO**
Does food become caught between your teeth?	**YES NO**
Is gum disease or tooth loss common in your family?	**YES NO**
Would you like to keep all your teeth all your life?	**YES NO**
What might prevent you from receiving proper dental care?	
Lack of desire for good health ...	**YES NO**
Inability to miss work/school ...	**YES NO**
Cost of quality care ...	**YES NO**
Do you feel nervous about having dental treatment? If so, what is your biggest concern? _____ _____	**YES NO**
Have you ever had an upsetting dental experience? If yes, please describe: _____ _____	**YES NO**

Have you ever had:	
Orthodontics (Braces)	**YES NO**
Oral Surgery	**YES NO**
Periodontal (gum) Treatment	**YES NO**
A bite adjustment, occlusal splint or mouth guard	**YES NO**
An injury to your mouth or head. If yes, explain below.	**YES NO**
Have you ever experienced:	
Clicking or popping of the jaw	**YES NO**
Pain (ears, joints, side of face)	**YES NO**
Difficulty in opening or closing mouth	**YES NO**
Grinding or clenching your teeth	**YES NO**
Sore or tired jaws in the morning	**YES NO**
Do You:	
Clench or grind your teeth while awake or asleep?	**YES NO**
Bite your lips or cheeks regularly?	**YES NO**
Hold foreign objects with your teeth? (pencils, etc.)	**YES NO**
Mouth breathe while awake or asleep?	**YES NO**
Smoke or chew tobacco?	**YES NO**
Frequently get cold sores, blisters, or other lesions?	**YES NO**

Are you satisfied with the appearance and function of your teeth ❑ Yes ❑ No Please Comment _____

Is there anything else about your dental treatment you feel we should know? _____

(PLEASE COMPLETE OTHER SIDE)

(Please see other side also)

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

(PLEASE COMPLETE OTHER SIDE)

NO SHOW/CANCELLATION POLICY

If you have an appointment for dental treatment that you are unable to keep, you must give us at least 24 business hours' notice for us to accommodate other patient needs.

If notice of the cancellation is not received within a **24 hour** time frame, we reserve the right to charge a **$25.00 cancellation fee**.

Due to the office not always being opened on Fridays, if you need to cancel a Monday appointment we ask that you do so on Thursday of the week prior within the **"24 hour"** time frame as if it were the day before.

If you have an appointment and do not show up or call, you may be charged a **$50.00 NO SHOW FEE**. Any such fees will be automatically charged to your account.

Appointments that have not been confirmed by the day prior to the appointment will be moved off the schedule.

We regret the need to implement this policy, but it allows us to provide the highest quality of dental care in the most efficient manner possible.

I have read and understand the above stated NO SHOW/CANCELLATION Policy.

Patient Signature:_____Date:_____

Parent Signature:_____Date:_____

(if patient under 18)

FINANCIAL POLICY

We are not in network with any insurance companies, but will gladly file any insurance you have excluding Medicaid and NC Health Choice. For our patients with insurance, we do ask that you pay 20% to 50% at the time of service for any restorative appointments, depending on the procedure. We do our absolute best to estimate your out of pocket cost, but this not a guarantee, only an estimate. The account holder is responsible for any leftover balance after insurance pays. Because some Delta Dental plans send payment directly to the patient, we do require patients with these plans to pay in full at the time of service. For our patients without insurance, we do ask for payment in full at the time of service for all appointments. We gladly accept Visa, MasterCard, Discover, American Express, Apple Pay, personal checks and cash. We do not do any in house financing and ask any balances be cleared by thirty days. For our patients that may need to finance treatment over a longer period of time, we are glad to accept Care Credit, which is an outside finance company that allows patients to finance their treatment with deferred interest through promotional offers.

For procedures in the amount or greater than 1500.00 we ask for a 10% deposit to hold your appointment time.

I have read and understand the above stated Financial Policy.

Responsible Party Signature:_____Date:_____

Notice of Privacy Practices (NPP)

Instructions for Use

The following are the **REQUIRED** changes to the NPP. Please review and ensure the current NPP in use is revised to include these items:

- Statement which outlines the types of uses and disclosures which will require authorization.
    - Release of psychotherapy notes – Do not have to include if do no record or maintain this information.
    - Disclosures for marketing purposes.
    - Disclosures for any purposes which require the sale of PHI.
- Statement that other uses and disclosures will not be made without written authorization.
- Notice of updated rights:
    - Right to restrict certain disclosures of protected health information to a health plan where the individual pays out of pocket in full for the health care item or service.
    - Will receive notification in the event of a breach scenario.
- Notice of fundraising communications and the opportunity to opt out.
    - Not required to include the opt-out process

TMC is pleased to provide an example of an updated NPP, which includes verbiage required by the recently published Omnibus HIPAA Rules. Please review the NPP carefully to ensure it reflects the current process of your facility. This NPP can be located in electronic format on our website in the Client Portal under HIPAA Forms.

Page 1

- Be sure to insert the name of your practice or facility.
- Contact information of the Privacy Officer should be included. The actual name of the person can be included, but PRIVACY OFFICER and contact information is sufficient. The rationale behind not including the actual name of the person is that if they should leave your organization, the NPP would need to be updated to include the current person holding the title.
- The effective date is the original date your facility adopted a NPP, which for many will be the April 2003 date. The revision date is the date you adopt the updated Notice.

Pages 2 – 4

- Review these pages carefully deleting any activities in which your facility does not participate, for instance fundraising activities, or providing appointment reminders.
- On page 4 in the section which outlines disclosures requiring a signed authorization, carefully review the definition of psychotherapy notes. If your facility does not create or

receive this type of protected health information you may delete this statement from your Notice. The statement about marketing and disclosures for sale of PHI must remain.

Providing the updated Notice of Privacy Practices

- Direct care providers are not required to print and hand out a revised NPP to all individuals seeking treatment. Providers are only required to give a copy of the NPP to, and obtain a good faith acknowledgment of receipt from, **NEW** patients.

Posting of the updated Notice of Privacy Practices

- Providers must post the revised NPP in a clear and prominent location and have copies of the NPP at the delivery site for individuals to request to take with them.
- Health care providers are required to post the NPP in a clear and prominent location at the delivery site, however providers may post a summary of the Notice in such a location as long as the full notice is immediately available (such as on a table directly under the posted summary) for individuals to pick up without any additional burden on their part. It would **not** be appropriate, however, to require the individual to have to ask the receptionist for a copy of the full NPP.
- If the facility has a website, the updated NPP must be posted on the website.

DRAKEDENTISTRY

Hometown Dentistry, Uptown Smiles

Alex Drake, D.D.S., P.A.

Notice of Privacy Practices

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.

If you have any questions about this Notice please contact the Privacy Officer.
Jessica Piper, CDA
(919) 693-9555

Effective Date: July 17, 2012 **Revised: July 11, 2022**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **www.myoxforddentist.com**

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- <u>If required by law:</u> The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- <u>Public health activities:</u> The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.

- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss

post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.

- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

<u>All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.</u>

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

<u>Your Privacy Rights</u>

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. Please submit your written request to our Patient Care Coordinator, Christy Edwards.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Jessica Piper, CDA (919) 693-9555

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on **July 17, 2012**