Rutledge PEDIATRIC DENTISTRY

The parent or guardian who brings the child to the appointment is responsible for payment at the time of service.

TELL US ABOUT YOUR CHILD

Child's Name________________________________
First MI Last

Nickname__________________ ☐ Male ☐ Female

Child's Birthdate ____/____/____ Child's Age______

School__________________________ Grade______

Home Phone (____)__________________________

Home Address_______________________________

City/State_____________________ Zip__________

Who does the child live with?___________________

Siblings we treat____________________________

PRIMARY DENTAL INSURANCE

Insurance Co Name___________________________

Insurance Co Address_________________________

City/State_____________________ Zip__________

Insurance Co Phone (____)____________________

Group #________________ID#________________

Policy Holder's Name_________________________

Relationship to patient_______________________

Policy holder birthdate____/____/____

Policy holder SSN_____________________________

Employer___________________________________

MOTHER'S INFORMATION

☐ Mother ☐ Stepmother ☐ Grandparent ☐ Other

Name______________________________________
First MI Last

☐ Married ☐ Single ☐ Divorced

Birthdate____/____/____

Home Phone (____)__________________________

Cell Phone (____)____________________________

Address____________________________________

City/State_____________________ Zip__________

Employer___________________________________

Work Phone (____)__________________________

SSN_________________ DL#_________________

Email______________________________________

☐ Brought patient today/responsible for account

FATHER'S INFORMATION

☐ Father ☐ Stepfather ☐ Grandparent ☐ Other

Name______________________________________
First MI Last

☐ Married ☐ Single ☐ Divorced

Birthdate____/____/____

Home Phone (____)__________________________

Cell Phone (____)____________________________

Address____________________________________

City/State_____________________ Zip__________

Employer___________________________________

Work Phone (____)__________________________

SSN_________________ DL#_________________

Email______________________________________

☐ Brought patient today/responsible for account

How would you prefer us to contact you regarding notice of upcoming appointments?

☐ Email ☐ Cell ☐ Home Phone

Info_______________________________________

HOW DID YOU HEAR ABOUT US?

____

____
Guardian Name

____
Guardian Signature

____
Date

Pediatric Medical History

Child's Full Name: ______________________ **Nickname:** __________ **Date of birth:** ___/___/_____
Gender: ❑ M ❑ F **Race/Ethnicity:** __________ **Height:** _____ **Weight:** _______ **Date of last physical examination:** __________
Name/address/phone of primary physician: ______________________________
Name/address/phone of medical specialists: ______________________________

Is your child being treated by a physician at this time? Reason ______________________ ❑ YES ❑ NO
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? .... ❑ YES ❑ NO
List name, dose, frequency & date started: ______________________
Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? .... ❑ YES ❑ NO
List date & describe: ______________________
Has your child ever had a reaction to or problem with an anesthetic? Describe ______________________ ❑ YES ❑ NO
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List ______________________ ❑ YES ❑ NO
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List ______________________ ❑ YES ❑ NO
Is your child up to date on immunizations against childhood diseases? .... ❑ YES ❑ NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions .... ❑ YES ❑ NO
Problems with physical growth or development .... ❑ YES ❑ NO
Sinusitis, chronic adenoid/tonsil infections .... ❑ YES ❑ NO
Sleep apnea/snoring, mouth breathing, or excessive gagging .... ❑ YES ❑ NO
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease .... ❑ YES ❑ NO
Irregular heart beat or high blood pressure .... ❑ YES ❑ NO
Asthma, reactive airway disease, wheezing, or breathing problems .... ❑ YES ❑ NO
Cystic fibrosis .... ❑ YES ❑ NO
Frequent colds or coughs, or pneumonia .... ❑ YES ❑ NO
Frequent exposure to tobacco smoke .... ❑ YES ❑ NO
Jaundice, hepatitis, or liver problems .... ❑ YES ❑ NO
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems .... ❑ YES ❑ NO
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions .... ❑ YES ❑ NO
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder .... ❑ YES ❑ NO
Bladder or kidney problems .... ❑ YES ❑ NO
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems .... ❑ YES ❑ NO
Rash/hives, eczema or skin problems .... ❑ YES ❑ NO
Impaired vision, hearing, or speech .... ❑ YES ❑ NO
Developmental disorders, learning problems/delays, or intellectual disability .... ❑ YES ❑ NO
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures .... ❑ YES ❑ NO
Autism/autism spectrum disorder .... ❑ YES ❑ NO
Recurrent or frequent headaches/migraines, fainting, or dizziness .... ❑ YES ❑ NO
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) .... ❑ YES ❑ NO
Attention deficit/hyperactivity disorder (ADD/ADHD) .... ❑ YES ❑ NO
Behavioral, emotional, communication, or psychiatric problems/treatment .... ❑ YES ❑ NO
Abuse (physical, psychological, emotional, or sexual) or neglect .... ❑ YES ❑ NO
Diabetes, hyperglycemia, or hypoglycemia .... ❑ YES ❑ NO
Precocious puberty or hormonal problems .... ❑ YES ❑ NO
Thyroid or pituitary problems .... ❑ YES ❑ NO
Anemia, sickle cell disease/trait, or blood disorder .... ❑ YES ❑ NO
Hemophilia, bruising easily, or excessive bleeding .... ❑ YES ❑ NO
Transfusions or receiving blood products .... ❑ YES ❑ NO
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant .... ❑ YES ❑ NO
Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS .... ❑ YES ❑ NO

PROVIDE DETAILS HERE: ______________________________

Is there any other significant medical history **pertaining to this child or his/her family** that the dentist should be told? .... ❑ YES ❑ NO
If YES, describe ______________________________

What is your primary concern about your child's oral health? ____________________

How would you describe:

your child's oral health?	☐ Excellent	☐ Good	☐ Fair	☐ Poor	
your oral health?	☐ Excellent	☐ Good	☐ Fair	☐ Poor	
the oral health of your other children?	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ Not applicable

Is there a family history of cavities? ☐ YES ☐ NO If yes, indicate all that apply: ☐ Mother ☐ Father ☐ Brother ☐ Sister

Does your child have a history of any of the following? For each YES response, please describe:

Inherited dental characteristics	☐ YES	☐ NO	____________
Mouth sores or fever blisters	☐ YES	☐ NO	____________
Bad breath	☐ YES	☐ NO	____________
Bleeding gums	☐ YES	☐ NO	____________
Cavities/decayed teeth	☐ YES	☐ NO	____________
Toothache	☐ YES	☐ NO	____________
Injury to teeth, mouth or jaws	☐ YES	☐ NO	____________
Clinching/grinding his/her teeth	☐ YES	☐ NO	____________
Jaw joint problems (popping, etc.)	☐ YES	☐ NO	____________
Excessive gagging	☐ YES	☐ NO	____________
Sucking habit after one year of age	☐ YES	☐ NO	If yes, which: ☐ Finger ☐ Thumb ☐ Pacifier ☐ Other ☐ For how long? _____

How often does your child brush his/her teeth? ________ times per ___________ Does someone help your child brush? ☐ YES ☐ NO

How often does your child floss his/her teeth? ☐ Never ☐ Occasionally ☐ Daily Does someone help your child floss? ☐ YES ☐ NO

What type of toothbrush does your child use? ☐ Hard ☐ Medium ☐ Soft ☐ Unsure

What toothpaste does your child use? ____________________

What is the source of your drinking water at home? ☐ City/community supply ☐ Private well ☐ Bottled water

Do you use a water filter at home? ☐ YES ☐ NO If YES, type of filtering system: ____________

Please check all sources of fluoride your child receives:

☐ Drinking water ☐ Toothpaste ☐ Over-the-counter rinse ☐ Prescription rinse/gel ☐ Prescription drops/tablets/vitamins

☐ Fluoride treatment in the dental office ☐ Fluoride varnish by pediatrician/other practitioner ☐ Other:____________

Does your child regularly eat 3 meals each day?	☐ YES	☐ NO	
Is your child on a special or restricted diet?	☐ YES	☐ NO	If YES, describe: ____________
Is your child a 'picky eater'?	☐ YES	☐ NO	If YES, describe: ____________
Does your child have a diet high in sugars or starches?	☐ YES	☐ NO	If YES, describe: ____________
Do you have any concerns regarding your child's weight?	☐ YES	☐ NO	If YES, describe: ____________

How frequently does your child have the following?

Candy or other sweets	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day	Product ________
Chewing gum	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day	Type ________
Snacks between meals	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day	Usual snack ________
Soft drinks*	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day	Product ________

(* such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Please note other significant dietary habits: ____________________

Does your child participate in any sports or similar activities? ☐ YES ☐ NO If YES, list: ____________

Does your child wear a mouthguard during these activities? ☐ YES ☐ NO If YES, type: ____________

Has your child been examined or treated by another dentist? ☐ YES ☐ NO

If YES: Date of first visit: ________ Date of last visit: ________ Reason for last visit: ________

Were x-rays taken of the teeth or jaws? ☐ YES ☐ NO Date of most recent dental x-rays: ________

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? ☐ YES ☐ NO If YES, when? ________

Has your child ever had a difficult dental appointment? ☐ YES ☐ NO If YES, describe: ________

How do you expect your child will respond to dental treatment? ☐ Very well ☐ Fairly well ☐ Somewhat poorly ☐ Very poorly

Is there anything else we should know before treating your child? ☐ YES ☐ NO

If yes, describe: ____________________

____

____________	____________	________	____________
Signature of parent/guardian	Relationship to child	Date	Signature of staff member reviewing history

MEDICAL/DENTAL HISTORY UPDATE

Is your child being treated by a physician at this time? Reason ____________	☐ YES	☐ NO
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? …………………………	☐ YES	☐ NO
List name, dose, frequency & date started: ____________		
Has your child had any illness, surgery, injury, allergic reaction, or medical emergency in the past year? …………………………	☐ YES	☐ NO
Describe: ____________		
Has your child ever had a reaction to or problem with an anesthetic? Describe: ____________	☐ YES	☐ NO
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List: ____________	☐ YES	☐ NO
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List ____________	☐ YES	☐ NO
Have there recently been any significant changes/disruptions to your child's family, home, or school routines? …………………………	☐ YES	☐ NO
Describe: ____________		
What is your primary concern regarding your child's oral health? ____________		
Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office? …………………………	☐ YES	☐ NO
Describe: ____________		
Has your child's diet changed significantly since his/her last dental visit? Describe: ____________	☐ YES	☐ NO
Has your child been treated by another dentist/dental professional since last visiting our office? Reason: ____________	☐ YES	☐ NO
Is there any other change in the child's medical, dental, or family history that the dentist should be told? …………………………	☐ YES	☐ NO
Describe: ____________		

____________	____________	________	____________
Signature of parent/guardian	**Relationship to child**	**Date**	**Signature of staff member reviewing history**

FINANCIAL AGREEMENT

Thank you for choosing Rutledge Pediatric Dentistry for your child's dental needs. As a courtesy to you, we will file your primary dental insurance claim for you if we have received all of your insurance information 48 hours prior to your appointment. It is your responsibility to be familiar with your insurance benefits, as you will be responsible for what insurance does not cover. You will be expected to pay your estimated uncovered portion (if any) at the time of service. We accept cash, checks, credit cards (Master Card, Visa, Discover), and Care Credit as forms of payment. There is also a **$35 fee** for returned checks. Once the insurance company reimburses our office, if there is still a balance, you will be billed for the remaining portion. If there is a credit, a refund check will be sent to you. Please be aware that our office does not file secondary insurance.

Please understand that your dental insurance is a contract between you and your insurance company. We are not responsible for how your insurance handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost and we will verify your benefits prior to treatment whenever possible. Please note that we only provide estimates, and only your insurance can determine exactly what they will pay on a claim once the claim is submitted. We will file a pre-determination for recommended treatment when it is requested by you. If your insurance company inadvertently sends the payment to you instead of our office, you will be responsible for the entire account balance.

Please be aware that the person bringing the child to our office is legally responsible for payment of all charges. In case of divorce or separation, the responsible party prior to the divorce or separation remains responsible for the account. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent (our office will not intercede or send statements to other persons). If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred.

Our office requests a **2 business days** notification if you are unable to keep your scheduled appointment. If less than a 2 business day notice is given, a **$25 fee** per child for exams and a **$50 fee** for treatment may be charged to your account. Patients with three missed appointments may be asked to transfer their records to another office. If your child is seen for an emergency visit after our regular business hours, we reserve the right to charge an "after hours" fee in addition to any treatment on that visit.

By signing this agreement, you are agreeing to all the statements above and below.

- I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for the services provided and I am financially responsible for payment in full on all accounts.
- I authorize payment of insurance benefits directly to the dentist.
- I authorize the release of any information concerning my child's dental care for the purposes of evaluating and submitting claims for insurance payment.

____   ____

Patient Name   Date

____   ____

Guardian Name (Printed)   Guardian Signature

____

Relationship to Patient

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.

OUR LEGAL DUTY

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/23/2015, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY SEND HEALTH INFORMATION ABOUT YOU

Your protected health information ("PHI") includes information relating to your mental or physical health and to the health care provided to you, including materials like your dental records, dental x-rays, and payment records. Some documents containing PHI may include such sensitive personal information as a Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse records, positive HIV status, and other kinds of sensitive information. Sometimes our dental practice needs to send PHI to the patient or to someone else, such as a specialist. There are various ways to send PHI, including email and other electronic means. Our dental practice does not encrypt email or other electronic forms of communication. There is a risk that unencrypted information may be acquired by hackers or received by unintended recipients. If you are concerned about the security of PHI that may be sent unencrypted, please let us know and we will send it a different way, which may include providing the information to you to deliver.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations.

Treatment. We may disclose your health information to a specialist providing treatment to you.

Payment. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. Healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;

- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.
Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.
Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.
Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.
Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.
Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.
Appointment Reminders. We may use or disclose your PHI to provide you with appointment reminders (such as voicemail, text messages, email, postcards, or letters).

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.
Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the address at the end of this Notice. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the address at the end of this Notice. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

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 if 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.

For questions please contact us at:
Rutledge Pediatric Dentistry
5323 W. University Dr. Suite 100
McKinney, TX 75071
Email: office@rutledgekidsdentist.com
Phone: 214-436-5555
Fax: 214-494-8944

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. These rights have been thoroughly explained to me in your *Notice of Privacy Practices.*

I acknowledge that I have received, read, and understand your *Notice of Privacy Practices*. I also understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization to obtain a current copy.

____
Patient Name

____
Guardian Name (Printed)

____
Guardian Signature

____
Relationship to Patient

____
Date

OFFICE USE ONLY

I attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but was unable to because:

Reason:________________________________ Initials:________ Date:______________