Apple Dental Center
19190 US Highway 18, Suite A
Apple Valley, CA 92307
info@appledentalcenter.org
http://www.appledentalcenter.org

We invite you to participate in our online system. Features include:

- Request Appointments Online
- Receive Text Message Appointment Reminders
- Refer Your Friends Online
- Confirm Appointments via Email
- Submit Patient Satisfaction Surveys

Please Verify Your Contact Information

Name _____

Address 1 _____

Address 2 _____

City _____

State _____ Zip _____

EMAIL _____

Home Phone _____

Work Phone _____

CELL PHONE _____

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

DENTAL HISTORY

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

MEDICAL HISTORY

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, pill or drugs? What? _____ Ever taken fen-phen? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives. Discuss _____

Do you now have or have you ever had any of the following? Please circle the appropriate letter Y=YES, N=NO.

* If yes to any of the starred conditions, please call prior to appointment...pre-medication may be required.

	Yes No		Yes No		Yes No		Yes No		Yes No
Heart Trouble/Disease	Y N	Bruise Easily	Y N	Emphysema	Y N	Yellow Jaundice	Y N	Cold Sores	Y N
Heart Murmur*	Y N	Anemia	Y N	Tuberculosis	Y N	Kidney Problems	Y N	Fever Blisters	Y N
Irregular Heartbeat	Y N	Excessive Bleeding	Y N	Cancer	Y N	Renal Dialysis *	Y N	Herpes	Y N
Angina/Chest Pain	Y N	Sickle Cell Disease	Y N	Radiation Treatment	Y N	Thyroid Disease	Y N	Stroke	Y N
Heart Attack/Failure	Y N	Hemophilia	Y N	Chemotherapy	Y N	Parathyroid Disease	Y N	Convulsions	Y N
Congenital Heart Disorder	Y N	Leukemia	Y N	Stomach/Intestinal Disease	Y N	Arthritis/Gout	Y N	Epilepsy or Seizures	Y N
Mitral Valve Prolapse*	Y N	Recent Blood Transfusn	Y N	Ulcers	Y N	Rheumatism	Y N	Fainting or Dizziness	Y N
Scarlet Fever	Y N	Swelling of Limbs	Y N	Recent Weight Loss	Y N	Pain in Jaw Joints	Y N	Glaucoma	Y N
Rheumatic Fever*	Y N	Lung Disease	Y N	Frequent Diarrhea	Y N	Cortisone Medicine	Y N	Tumors or Growths	Y N
Artificial Heart Valve*	Y N	Breathing Problem	Y N	Diabetes	Y N	**Artificial Joint***	Y N	Nervousness	Y N
Heart Pace Maker*	Y N	Shortness of Breath	Y N	Excessive Thirst	Y N	Venereal Disease	Y N	Psychiatric Care	Y N
Heart Surgery	Y N	Frequent Cough	Y N	Hypoglycemia	Y N	**AIDS**	Y N	Alzheimer's Disease	Y N
High Blood Pressure	Y N	Hay Fever	Y N	Liver Disease	Y N	**HIV Positive**	Y N	**Allergies (Medicines)**	Y N
Low Blood Pressure	Y N	Sinus Trouble	Y N	**Hepatitis A (Infectious)**	Y N	Genital Herpes	Y N	Allergies (Pollen/Dust)	Y N
Blood Disease	Y N	**Asthma**	Y N	**Hepatitis B or C**	Y N	**Drug Addiction**	Y N	Hives or Rash	Y N
Unexplained Fever	Y N	Bloody Sputum	Y N	Night Sweats	Y N				

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____

History Review and Significant Findings _____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT SIGNATURE	BP	REVIEWED BY
_____	_____	None ☐	_____	_____	_____
_____	_____	None ☐	_____	_____	_____
_____	_____	None ☐	_____	_____	_____
_____	_____	None ☐	_____	_____	_____

PATIENT INFORMATION

DATE _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

ADDRESS _____
STREET APT.# CITY STATE ZIP
Email address _____

BIRTH DATE _____ TELEPHONE _____
MONTH DAY YEAR HOME # WORK # CELL#

PLACE OF EMPLOYMENT _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____
(SS# or Certificate #)

Has any member of your immediate family ever been treated in our office? ☐ YES ☐ NO Name: _____
How did you hear about our office? ☐ Friend/Family _____ ☐ Internet Search
Yellow Pages: ☐ Verizon/Superpages ☐ YellowBook ☐ Local Pages
Other: _____

FAMILY INFORMATION

Fill in both shaded blocks for minor child. Fill in appropriate shaded block for adult.

FATHER (OR HUSBAND)

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

BIRTH DATE (MM/DD/YY) SS#

EMPLOYER

DENTAL INSURANCE CO. SUBSCRIBER # GROUP #

MOTHER (OR WIFE)

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

BIRTH DATE (MM/DD/YY) SS#

EMPLOYER

DENTAL INSURANCE CO. SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or health professionals.

X _____
___Adult Patient ___Father/Husband ___Mother/Wife ___Guardian

_____
Date State Driver's License #

PERSON RESPONSIBLE FOR ACCOUNT

Please check one

☐ Patient ☐ Father (or Husband)

☐ Guardian ☐ Mother (or Wife)

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐ YES ☐ NO

☐ Payment in full at each appointment (cash / personal check)

☐ Payment in full at each appointment (credit card)
VISA MC AMEX DISCOVER
Card # _____ Exp Date _____

SERVICE CHARGE

If I do not pay the entire balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below,
and read and sign the section at the bottom of form.

Patient Name _____

PLEASE SIGN HERE _____ DATE _____

☐ **1. WORK TO BE DONE**
I understand that I am having the following work done: Fillings ____, Bridges ____, Crowns ____, Extractions ____, Impacted teeth removed ____, General Anesthesia ____, Root Canals ____, Other _____
(Initials _____)

☐ **2. DRUGS AND MEDICATIONS**
I understand that antibiotics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). (Initials _____)

☐ **3. CHANGES IN TREATMENT PLAN**
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials _____)

☐ **4. REMOVAL OF TEETH**
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw.
(Initials _____)

☐ **5. CROWN, BRIDGES AND CAPS (permanent & Stainless Steel)**
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. (Initials _____)

☐ **6. DENTURES, COMPLETE OR PARTIAL**
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (Initials _____)

☐ **7. ENDODONTIC TREATMENT (ROOT CANAL) (Pulpotomy)**
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials _____)

☐ **8. PERIODONTAL LOSS (TISSUE & BONE)**
I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials _____)

☐ **9. SEDATION (Nitrous Oxide, Oral Conscious Sedation and/or Intraveneous Sedation)**
I understand that analgesia can cause nausea and vomiting, and have been advised that the patient is not to eat or drink 2-4 hours prior t treatment. I further understand that the fee for such services are my responsibility including all arrangements to be made through my insurance. I agree and hereby give my consent. (Initials_____)

I understand that dentistry is not an exact science and that , therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

Signature of Responsible Party _____ Date _____

Witness _____ Date _____

ABOUT FINANICAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for service is due at the time services are rendered. We accept cash, checks, MasterCard/VISA, Discover, American Express and Care Credit (on approved credit). If you have a dental benefit plan, we will bill your claims for you at no charge. If you assign benefits to us, you will only be required to pay your **estimated** portion as treatment is completed. We will provide you with an estimate based on our knowledge of your particular dental plan at the time of your examination. In the event that the insurance carrier rejects your claim, or the amount paid is less than what was estimated, you will be responsible for full payment of the balance.
Balances older than 30 days may be subject to additional service charges of 1.5% per month or a minimum of $3.00 per month, whichever is greater. There is a $25.00 charge for a returned check. Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice, at a rate of $25.00 per hour missed.
We will gladly discuss your proposed treatment and answer any questions relating to your dental coverage. You must realize however that:

1. Your dental benefit program is a contract between you, your employer and the insurance company. We are not party to that contract.
2. Our fees may not be covered in full by the maximum allowance determined by your dental carrier. Occasionally carriers will set their reimbursement rates lower than the "UCR" (usual, customary and reasonable) fees for this region in order to save costs. This causes a higher "out of pocket" expense to the patient. That portion that the insurance carrier does not pay is due by you.
3. Not all services are a covered benefit in all contracts.
4. You are responsible to us for all fees for services rendered to you and your family members.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility for the date the services are rendered. We realize that temporary financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I understand that dentistry is not an exact science, and therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee of assurance has been made by anyone regarding this dental treatment which I am requesting and authorizing. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me, or my family.

I hereby authorize any of the doctors or dental auxiliaries of Apple Dental Center to proceed with and perform the dental treatment that has been/will be explained to me. I understand that I will be given an estimate subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of all dental fees. I agree to pay any attorney's fees, or court costs that may be incurred to satisfy that obligation.
I agree to that a photocopy of this authorization shall be valid and effective as the original forever. I am of legal age and legally competent to make this assignment for myself or for any of my dependents.

I will also inform the doctors or dental auxiliaries of any changes in my medical history, insurance and/or address without fail.

I certify that I have had an opportunity to read and fully understand the terms and words within the above and have had the opportunity to have any questions answered to my satisfaction.

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

apple DENTAL CENTER

Patient Receipt of Dental Materials Fact Sheet

I acknowledge that I have received and have read a copy of the Dental Materials Fact Sheet dated May 2004 from Apple Dental Center.

_____ _____

Patient Signature Date

This information is available for review in it's entirety on the Dental Board website.
http://www.dbc.ca.gov/formspubs/pub_dmfs_english_webview.pdf

The following is a sample of the Dental Board of California Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this document and it's linkage to the DCA web site does not constitute an endorsement of the content of this document.

The Dental Board of California
Dental Materials Fact Sheet
Adopted on 10/17/2001

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin ionomer cement, ceramic porcelain, and porcelain fused to metal, gold alloys (noble) and nickel or cobalt-chrome (base metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors and compared in the referenced matrix titled "Comparisons of Restorative Dental Materials". A glossary of terms is also referenced to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993 – 2001. In some cases, where contemporary research is spare, they have indicated the best perceptions based upon information that pre-dates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made. The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the work will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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 November 1, 2002, 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 $0.25 for each page, $ 10.00 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.

Contact Officer: L. J. Morrison

Telephone: (760) 242-7753 Fax: _____

E-mail: ljmrdaef@earthlink.net

Address: 19190 Highway 18, Ste A Apple Valley, CA 92307
