SMILES BY MIA
COSMETIC & GENERAL DENTISTRY

(703) 323-1300
8989 Fern Park Dr.
Burke, VA 22015

New Patient Letter

Dear Patient,

Welcome to our Smiles by Mia dental family! Thank you for giving us the opportunity to provide you with excellent dentistry in our modern, comfortable and spa like environment. Please know that your needs and comfort are our top priority. We are committed to providing the highest quality dental care with the latest technologies and deliver them with a gentle touch. Our team attends many continuing education courses every year so that we can improve our skills in order to provide our patients with the best dental techniques.

We understand that every patient is unique, and we strive to work together as a team to address everyone's needs. We will provide you with different treatment options that will work within your budget. We never want money to be the reason why our patients do not get the care they need, so we offer Carecredit, Lending club, and in-house payment plans.

Enclosed you will find our new patient forms. Please read through them, fill them out and bring them to your appointment.

We look forward to meeting you. During your first visit we will take a full set of x-rays, intra-oral images and do periodontal gum measurements to determine the type of cleaning you will need. Dr. Mia will do a thorough examination of your mouth and will go over all the x-rays, intra-oral photos and her recommendations for you. We are very detailed and thorough, so we have reserved 1 hour and 30 minutes especially for you. Please be kind and let us know 3 days in advance if you need to re-schedule this appointment.

If you have any questions prior to your appointment, please don't hesitate to call us at (703) 323-1300. Again, thank you for choosing our office. We look forward to meeting you.

Sincerely,

Dr. Mia Pham Sanchez de Lozada

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New Patient Registration

First Name: _____ Last Name: _____ Middle Initial: _____
Patient is: ☐ Responsible Party ☐ Policy Holder ☐ Dependent
Address: _____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-Mail _____
Sex: ☐ Female ☐ Male Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Birth date: _____ Social Security #: _____ Drivers Lic#: _____
Employment Status:
☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Unemployed ☐ Student ☐ Minor

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insurance Company: _____ Employer Name: _____
Employer ID: _____ Group #: _____
Policy Holder Social Security #: _____ Policy Holder Birth Date: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name: _____ Insurance Company: _____
Employer ID: _____ Group #: _____
Policy Holder Social Security #: _____ Policy Holder Birth Date: _____

Medical Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name: _____ Insurance Company: _____
Employer ID: _____ Group #: _____
Policy Holder Social Security #: _____ Policy Holder Birth Date: _____

Emergency Contact

First Name: _____ Last Name: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

How did you hear about our office? _____
When was your last dental visit? _____
Do you have any dental concerns, if yes please specify? _____
_____
_____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ nuts _____		
☐ fruit _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months ___	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox ___	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco ___	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]_____ ☐ ☐
2. Have you had an unfavorable dental experience?_____ ☐ ☐
3. Have you ever had complications from past dental treatment?_____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?_____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?_____ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma?_____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?_____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?_____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?_____ ☐ ☐
20. Do you frequently get food caught between any teeth?_____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your back teeth together?_____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed?_____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?__ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?_____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench or grind your teeth together in the daytime or make them sore?_____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?___ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?_____ ☐ ☐
34. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

LUMINEERS® SMILE EVALUATION

A simple questionnaire to help you get the smile you've always wanted

Hold a mirror 12"–14" from your face. Smile to show your teeth. Look at your teeth very carefully, then answer the following questions. If you are not happy with the appearance of your teeth, ask your dentist how LUMINEERS can give you a beautiful, white smile.

1 Do you like the appearance of your teeth and smile? ☐ Yes ☐ No
If not, explain _____

2 Are your teeth all in alignment (straight)? ☐ Yes ☐ No
If not, explain _____

3 Do you have spaces that you don't like? ☐ Yes ☐ No
If yes, explain _____

4 Do you like the color of your teeth? ☐ Yes ☐ No
If not, explain _____

5 Do you like the shape of your teeth? ☐ Yes ☐ No
If not, explain _____

6 Are your teeth
chipped? _____ protruding? _____ hidden? _____

7 Are your teeth wearing down on the biting surfaces? ☐ Yes ☐ No
If yes, explain _____

8 Are there old fillings or dental work you don't like looking at? ☐ Yes ☐ No
If yes, explain _____

9 What would you like to change the most about the appearance of your teeth?

10 How would you like your teeth to look?

11 Would you like to see a photo of how your smile could look with LUMINEERS?
☐ Yes ☐ No

Bring out your beautiful, white smile today!

LUMINEERS®
beautiful smile. beautiful you.

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Office Financial Policies

Dear Patient,

The primary goal of our practice is to provide the highest quality dental care to our patients. Since our practice also has financial obligations which must be met, we ask you to note the following statements of our financial policy.

Treatment Plans and Estimates:

Treatment plans are merely an estimation of planned procedures diagnosed before treatment and can change as treatment progresses. It is often impossible to predict the exact cost of the treatments until they are rendered.

Methods of Payments:

Cash, Check, VISA, Master Card, Discover, American Express, Care Credit, Lending Club.

Co-Payments will be collected at check-in prior to you having treatment rendered.

A credit card will be required to be kept on file for Administrative Charges below. Rest assured; we will never disclose this credit card information to anyone else.

Administrative Charges:

Checks returned by the bank per incident	$35
Account balances over 90 Days	$25
Missed and cancelled appointments without proper notice	$50 per hour
Collection agency fees	1.9% per month
Any X-Ray copy requests	$20

**No cancellations can be left on the voicemail. Cancellations must be made during business hours (Monday-Thursday) 3 business days in advance.

**Collection agency: Patient is responsible for all fees incurred, including attorney & court costs. (Interest rates will be assessed at a rate of 1.9% per month.)

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Office Financial Policies

Dental Insurance:

- Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexity of insurance contracts. As a courtesy to you, we will file dental insurance claims on your behalf, but you will be fully responsible for your account if the insurance company does not pay.

- Your insurance plan is a contract between you (or your employer) and the insurance company. Specific questions about eligibility and plan coverage should be directed to your insurance or your employer.

AUTHORIZATION

I have read and fully understand the above information. I understand that I am responsible for (regardless of insurance coverage) any charges incurred from serviced rendered. I agree to be responsible for all charges not paid by my dental plan. I hereby authorize Smiles By Mia to administer such medications and perform such diagnostic, photographic 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 other health professionals.

I have read this office policy. I understand and agree to the terms of this financial policy.

Patient Name (Please Print) _____

_____ _____

Signature of Patient or Financially Responsible Party Date

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COSMETIC & GENERAL DENTISTRY

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HIPPA NOTICE

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 AND SIGN THE ACKNOWLEDGMENT BELOW.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes what rights you have and how we protect your health information.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you, examining your teeth, prescribing medications and faxing them to be filled, referring you to another doctor or clinic for other health services, or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes: asking you about your health or dental care plans, asking you for sources of payment, preparing and sending bills or claims, and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must do in order to run our office. We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for any reason, we will ask you for special written permission.

We will ask for special written permission in the following situations: x-ray requests, release of dental records to another dentist or an authorized person.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us and some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices.
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else.
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations.
- Uses or disclosures for health-related research.

(703) 323-1300
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HIPPA NOTICE

- Uses and disclosures to prevent a serious threat to health or safety.
- Uses or disclosures for specialized government functions, such as for the protection of the President or higher-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service.
- Disclosures of de-identified information.
- Disclosures relating to worker's compensation programs.
- Disclosures of a "limited data set" for research, public health, or health care operations.
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures.
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We call, email, text or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We also call, email, text or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, when we call, we would leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.

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HIPPA Notice

- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate these requests if they are reasonable. You will be responsible for any extra cost accrued. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.

- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, you will be able to review or have a copy of your health information within 30 days of asking us (or 60-days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60-days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.

- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60-days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

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HIPPA NOTICE

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint.

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free Call Center: 1-877-696-6775

ACKNOWLEDGEMENT OF NOTICE OF PRIVATE PRACTICES (HIPPA)

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that the following are a few highlights as to how this information can and will be used:

1. **Treatment:** Provide and coordinate my treatment with other heath care providers who may be involved in my treatment directly and indirectly.

2. **Payment:** Obtain payment from third-party payers for my health care services.

3. **Healthcare Operation:** Conduct normal health care operations such as quality assessment and improvement activities.

4. **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters, emails, or texts).

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Print Name): _____

_____ _____
Signature of Patient or Guardian Date:

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Patient Authorization to Release of Material for Office Use

I understand that the purpose of this authorization is to give permission to Smiles by Mia to use photographs taken of me and my family, our story and similar materials (collectively, the "material") for the purpose of promoting the practice of Smiles by Mia. I hereby authorize Dr. Mia and any employees of Smiles by Mia to use any or all this material for any and all purposes, including without limitation: in AACD publications and advertisements; on web sites and exhibit booths; posting of social media and website; and in educational programs and related documentation and templates. This authorization shall apply to any successor or assignee of Smiles by Mia.

I understand that I will receive no compensation for use of the material. I will take no action against any party described in this authorization based on that party's use of the material unless such use or publication is malicious. I understand that the material may be modified by Smiles by Mia or its agents and I will not object to any such modification. I waive any right to inspect and/or approve the specific use of the material and/or associated text. My consent is freely and carefully given to the extent permitted under applicable law.

I understand that information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may not be protected by applicable privacy laws. I may receive a copy of the signed authorization upon request.

Patient's Signature: _____ Date: _____

Print Patient's Name: _____

If this authorization is signed by a personal representative of the patient (e.g., a guardian of a young child) sign above as yourself and complete the following:

Personal Representative's Name: _____

Relationship to the Patient: _____