Transit Valley Dental Care, P.L.L.C.

JOHN N. ATHANS, DDS

Welcome to Our Practice!

Thank you for choosing our office to care for your dental needs. We are delighted to welcome you to our dental family and appreciate the opportunity to provide you with quality dentistry.

The New Patient Welcome Packet includes several important documents to read and complete. Please remember to fill out the Patient Information Sheets and bring to your first visit with us. Also, please bring any insurance information you wish to utilize.

At the first visit, we will take the time to discuss your dental goals and address any concerns you have. You will receive a comprehensive examination, dental photographs, low dose (digital) x-rays and cancer screening. The examination will serve as a baseline exam in which we compare future dental changes to. The hard and soft tissues of the mouth are examined and documentation of existing conditions takes place. A periodontal screening is done to determine the health of the gums and supporting bone and tooth structure. This will enable us to determine what type of dental hygiene treatment you will need and we can develop a customized dental plan together.

We have reserved an appointment for you and have enclosed an appointment reminder card. Please be aware that this time has been reserved specifically to meet your needs. Dr. Athans does not "double book" his patients so if you are unable to make this appointment, we ask that you give us 48 hours notice (two business days) to reschedule or cancel. Please call us at (716) 688-0777 if you are unable to commit to this date and time.

We are happy to file your insurance forms for you and it depends on your benefit plan as to whether or not the benefit check will be paid directly to the subscriber or will come here. Should your insurance plan mail the check to the subscriber, you will be responsible for full payment at the time of this appointment.

Thank you again for choosing our office for your dental needs. We look forward to providing you with the quality dental care you deserve.

John N. Athans, DDS

** Please remember to arrive at the office 20 minutes before your appointment time to complete new patient registration. Thank you. **

Phone (716) 688-0777 **Fax** (716) 688-7425 8840 Transit Road, East Amherst, NY 14051

Email: drathans_office@verizon.net

Transit Valley Dental Care

John N. Athans, Jr., DDS
8840 Transit Road * East Amherst, NY 14051

WELCOME! We are pleased to welcome you to our practice. Our goal is to help you reach and maintain excellent oral health. Please complete this form as completely as possible. Communication is vital so we can care for all your dental needs. We look forward to working with you in creating the smile of your dreams and maintaining your optimum dental health. If you have any questions, we will be happy to assist you.

PATIENT INFORMATION

Patient's Name: _____ **Date:** _____
Last First M.I. Nickname

Address: _____ _____ _____ _____
Street City State Zip

Email: _____@ _____

Gender: ☐ Male ☐ Female **Family Status:** ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Child ☐ Other _____

Social Security #: ___-_____-_____ **Birth Date:** _____

Driver's License #: _____ **Office Use Only: Copy in File? ☐ Yes ☐ No

Telephone Numbers:

Home: _____ ☐ Yes ☐ No Best time to call: _____

Work: _____ Ext: _____ ☐ Yes ☐ No Best time to call: _____

Cell Phone: _____ ☐ Yes ☐ No Best time to call: _____

Employer: _____ **Occupation:** _____

Employer's Address: _____
City State Zip Telephone No.

In case of an emergency, contact: _____ **Phone:** _____

RESPONSIBLE PARTY/PARENT/GUARANTOR INFORMATION

If person responsible for this account IS NOT the patient, complete the following information for the Guarantor:

Person Responsible for Account: _____

Gender: ☐ Male ☐ Female **Family Status:** ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Child ☐ Other _____

Address: _____ State _____ Zip _____

Social Security #: ___-_____-_____ **Birth Date:** _____

Telephone Numbers: Home: _____ Work: _____ Ext: _____

Cell Phone: _____

Employer Name: _____ **Occupation:** _____

When was your last visit to a dentist? _____ **What did you have done?** _____

Former Dentist _____

How often do you brush? _____ **How often do you floss?** _____ **Do you smoke? Circle: Yes No**

Check if you have had or have experienced any of the following:

_____ **Bad Breath**	_____ **Food collection between teeth**	_____ **Sensitivity to hot**
_____ **Bleeding gums**	_____ **Loose teeth or fillings**	_____ **Sensitivity to sweets**
_____ **Clicking or popping jaw**	_____ **Periodontal treatment**	_____ **Pain or sensitivity when biting**
_____ **Grinding or clenching**	_____ **Sensitivity to cold**	_____ **Sores or growths in mouth**

PATIENT NAME _____ DOB _____

REFERRAL INFORMATION

How did you learn about or who referred you to our dental office?

☐ Patient/Friend ☐ Our Staff ☐ Yellow Pages ☐ Another Dental Office ☐ Newspaper ☐ TV ☐ Website ☐ News Bulletin ☐ Your Employer

☐ Direct Mail Postcard ☐ Insurance Plan ☐ School ☐ Other:_____

Name of the person or dental/medical office who referred you: _____

INSURANCE INFORMATION

Primary Dental Insurance

Name of Primary Subscriber/Insured: _____ Is the insured a patient? ☐ Yes ☐ No

Relationship to Patient:
Social Security #: _____-_____-_____ Birth Date: _____ Date Employed: _____

Insured's Address: _____
Street City State Zip Code

☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insured's Employer Name: _____ Work Phone: _____ Ext: _____

Address: _____
Street City State Zip Code

Insurance Carrier/Plan Name: _____ Insurance Group #: _____

Insurance ID #: _____

Insurance Company Address: _____

Secondary Dental Insurance

Name of Secondary Subscriber/Insured: _____ Is the insured a patient? ☐ Yes ☐ No

Relationship to Patient:
Social Security #: _____-_____-_____ Birth Date: _____ Date Employed: _____

Insured's Address: _____
Street City State Zip Code

☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insured's Employer Name: _____ Work Phone: _____ Ext: _____

Address: _____
Street City State Zip Code

Insurance Carrier/Plan Name: _____ Insurance Group #: _____

Insurance ID #: _____

I affirm information I have given is correct and true to the best of my knowledge. If there is any change in my medical status, I will inform the dentist immediately. I certify that I have dental insurance as listed above and assign benefits directly to Transit Valley Dental Care, John N. Athans Jr., DDS and associates. Transit Valley Dental Care may use my health care information and disclose such information for purposes of obtaining payment and determining benefits. I authorize use of my signature on all insurance claims.

I further understand that my insurance carrier may pay less than the actual bill for services and understand that I am financially responsible for all fees, whether or not paid by my insurance carrier, for myself, and/or dependents.

Signature of Patient, Parent and/or Guardian:_____

TRANSIT VALLEY DENTAL CARE
JOHN N. ATHANS, JR., DDS

FINANCIAL, APPOINTMENT AND OFFICE POLICIES

Please read completely. If you have questions, please see staff.

Welcome to our office. *Dr. Athans and his staff are proud to be part of a team whose primary mission is to deliver the highest quality dental care so that our patients attain optimum oral health and keep their smiles healthy and beautiful for a lifetime. In addition, we strive to provide excellent customer service and will inform you of what procedures are necessary and what the estimated fee for your treatment will be prior to your appointment. To assist you with your healthcare investment, we provide the following payment options:*

No Insurance: Payment in full is due at the time of treatment.
Patients with Insurance: Estimated co-shares and deductibles are due at time of treatment.

Payment Options:

1. **Cash or check**
2. **Major credit cards (Visa, Mastercard, Discover and American Express)**
3. **Care Credit™ Payment plan – 6 and 12 month terms, offers no and low interest options. Instant approval available - allowing you to start treatment immediately**

If necessary, we may require a non-refundable deposit at the time of scheduling an appointment that may require blocking off a large segment of treatment time.

Patients with Insurance

Transit Valley Dental Care will work with your insurance carrier to make the most of your yearly dental benefits. We are not a contracted provider with any insurance plan. This allows us to provide the best care for our patients based on their needs, not insurance benefits. The following identifies our policies governing insurance claims:

A) Transit Valley Dental Care provides insurance company billing as a courtesy to our patients and will file the claims, necessary x-rays, and documentation for you to obtain maximum reimbursement from your insurance carrier. You are responsible for providing correct insurance information.

B) We require that you pay the patient's estimated portion of all fees, co-shares, and deductibles at time of service. After final payment has been received from your insurance carrier, you have 30 days to pay any remaining balance. We will mail a monthly statement for any account balance.

C) We will not become involved in disputes between you and your insurance carrier. We will attempt to provide an estimate of insurance benefits; however, estimates of co-shares and insurance pre-determinations are not a guarantee of payment. Your insurance carrier and plan benefits ultimately determine the amount paid or not paid.

D) All charges incurred are your responsibility regardless of what is or is not paid by your insurance carrier. Our relationship is with you, not your insurance carrier. We base our treatment recommendations on what we feel is best for you and not necessarily on what your insurance will, or will not, cover.

E) Insurance claims are usually paid within 30-60 days from the date of service. If your insurance carrier has not paid the claim on a timely manner, we ask that you be prepared to pay the unpaid balance.

Returned Checks

A check return fee of $50.00 will be added to any account that incurs a returned check from their bank, no matter what the reason. The account balance and $50.00 fee must be paid immediately upon notice.

Account Balance/Payments/Collections

Our billing system runs on a 30 day billing cycle and payment is expected within the allowable time frame. Should it become necessary to prepare and send a second statement, the account will be charged a $ 5.00 billing fee. Accounts that remain unpaid for 60 days or more will incur a service charge of 1.5% per month. The practice cannot carry any balance over 90 days. If payment problems do occur, we encourage you to contact our office(s) promptly for assistance in management of your account.

Patients will be informed when accounts are delinquent so they can avoid additional collection fees. If an account becomes delinquent or in default and it is necessary to forward an unpaid account to a collection agency, the account holder agrees they will be responsible for additional legal/collection fees up to 35% of balance due. Transit Valley Dental Care and John N. Athans, DDS reserve the right to terminate or dismiss a patient if their account becomes delinquent.

Minors/Parents/Legal Guardians

Only a parent or legal guardian can request dental services for a minor. A parent or legal guardian must bring in the child and must complete and sign the patient registration packet. If a person bringing in a minor is the legal guardian, you may be required to provide legal proof of guardianship. If anyone other than the parent or legal guardian (i.e. grandparent, aunt, etc.) brings in the child for subsequent appointments, the office must be notified in advance. The parent or legal guardian may be required to provide a signed request for treatment.

The person signing the registration papers for a child will be considered the responsible party and the account holder. They are solely responsible for all fees incurred during the visit. We will not become involved in any payment plans or disputes between divorced or separated parents.

LATE CANCELLATION/FAILED OR BROKEN APPOINTMENTS

Your appointment time is time reserved just for you and you alone! When you make an appointment, we reserve a treatment room, staff, and equipment for you. **Our office requires a minimum of 48-hour notice (2 business days) for any cancellation or rescheduling of an appointment**. **Appointments 2.5 hours or more require the minimum notice of 7 business days to cancel or reschedule an appointment. Last minute cancellations or missed appointments constitute a broken appointment and will result in a $75.00 per hour broken appointment fee.** Excessive missed appointments may require a non-refundable credit card deposit to hold the appointment date and time or possible dismissal from practice.

Remember: Advance notice allows us enough time to offer the appointment time to another patient.

AGREEMENT:

1) ***I have read, understand, and accept The Financial/Dental Insurance/Office Policy Agreement outlined above. I understand that this agreement applies to all individuals on my account. I agree to pay all charges for myself and members of my family promptly unless other credit arrangements have been made with the office. In the event of default of payment on an account, I agree to pay all additional legal/collection fees. I understand that all photographs, radiographs, and treatment records are the property of Transit Valley Dental Care and Dr. John N. Athans.***
2) ***I have read, understand, and agree that Transit Valley Dental Care and John N. Athans, Jr., DDS require 48-hour notice when cancelling or rescheduling an appointment. I further understand that should I fail to cancel within the required time, I will be charged a broken appointment fee of $75.00 for each hour scheduled.***

Signature of Patient/Patent/Legal Guardian: _____

Please Print Name of Patient/Parent/Legal Guardian: _____

Form Revised 8/20

TRANSIT VALLEY DENTAL CARE

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 _____

Transit Valley Dental Care, PLLC

John N. Athans, DDS

Dear Patient,

In order for us to stay compliant with HIPAA guidelines, please list below anyone that you authorize us to disclose information to regarding your Protected Health Information (PHI). It is not mandatory that you list anyone.

	Name	**Relationship**
1.	_____	_____
2.	_____	_____

Do we have your permission to leave information on your **answering machine** or **voicemail** if we are unable to reach you? ____ Yes ____ No

What is the best number to contact you at: _____.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Patient or Parent/Guardian Signature Today's Date

HIPAA PRIVACY FORM 2

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

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

Please Print Name Legibly

_____ _____

Patient or Parent/Guardian Signature Today's Date

Our office attempted to obtain the patient's acknowledgement of receipt of Notice of Privacy Practices but was unable to do so.

Reason acknowledgment not obtained: _____

Employee Signature:_____ Date: _____

Transit Valley Dental Care, PLLC

John N. Athans, DDS

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 practice, 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 April 14, 2003 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 policy 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 out 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 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, 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 location 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 disclosing 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 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, 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 the 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 to your health information by sending us a letter to the end of this notice. If you request copies, we will charge you $0.75 for each page. 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 Account: you may have the right to receive a list of instances in which we or out business associates disclose 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 out use or disclosure of your health information. We are not required to agree to these 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 this 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 made in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Questions and Complaints

If you want more information about our privacy practices, or have questions or concerns, please contact us.

If you are concerned 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 may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services upon request.

We support your right to privacy of your health information. We will retaliate in any way if you choose to file a complaint with us, or the US Department of Health and Human Services.

Contact Officer:	**Linda Greenfield**
Telephone:	716-688-0777
Fax:	716-688-7425
Address:	8840 Transit Road, East Amherst, NY 14051