



**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder Preferred Name: \_\_\_\_\_  
 Responsible Party

Responsible Party (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

Patient Information

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec.: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status:  Full Time  Part Time  Retired

How did you hear about our office?

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec.: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec.: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

# Pennyryle Family Dentistry

## Medical History

PATIENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

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

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_

I agree to reimburse Pennyryle Family Dentistry the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of **33.3 %** of the amount due at the time your account is placed with a collection agency, and all cost and expenses incurred for any collection efforts on your account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical/dental treatment and services until revoked by either party in writing.

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 health. It is my responsibility to inform the dental office of any changes in medical status

SIGNATURE OR PATIENT, PARENT, OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

# Pennyrile Family Dentistry, LLC

Dr. Joseph Falco, Dr. Ryan Vonnahme and Dr. Zachary Garnett

## Patient's Guide for Controlled Substances

Due to a new state law, your physician must take additional steps before prescribing certain controlled substances.

Your Dentist is required to obtain a **KASPER** (Kentucky All Schedule Electronic Reporting System) report on you prior to prescribing any controlled substance. KASPER is an electronic monitoring system that provides information on controlled substances you have been prescribed and had filled in Kentucky or other participating state pharmacies. Other requirements of the law include taking a medical history, performing a physical exam, and obtaining written consent.

Controlled substances can be used effectively to treat acute pain to allow you to recover from surgery, injury or other condition. This type of treatment rarely causes addiction. Medication should be discontinued when the condition is improved.

To reduce your chance of developing an addiction, you should take medications exactly as prescribed by your doctor. Also, be sure to let your doctor know of all other medications you are taking, including over the counter medications or herbal supplements.

You should also let your doctor know if you:

- Experience an increase in the amount of medication you need
- Are unable to limit or stop the medication use
- Experience withdrawal symptoms when stopping the medication (such as sweating, anxiety, nausea and vomiting, etc.) as these can be a sign of addiction.

Any unused medication may be taken to your local law enforcement office for disposal. You may also, in accordance with the FDA recommendations for disposal, remove the medication from its original container and mix with an undesirable substance, such as used coffee grounds or kitty litter, then place in the household trash. Medications should not be flushed down the drains. When in doubt, you should speak to your pharmacist.

## Consent for Treatment with Controlled Substances

I understand there are benefits and risks associated with taking controlled substances, including the risk of developing drug tolerance or dependence. I am aware of the risks, benefits, and alternatives. I consent to treatment with a controlled substance if my doctor deems it appropriate.

Also, by signing this consent, I am verifying that I am not receiving pain medication by any other provider that my doctor is not aware of. If it is determined that I am receiving pain medication from another provider, I understand there will be no future prescriptions written.

This consent is valid one calendar year from the date signed.

**Patient Signature or Person Authorized to Sign for the Patient:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Patient SSN:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient Address:** \_\_\_\_\_

**Pharmacy Name and Number:** \_\_\_\_\_

**Doctor:** \_\_\_\_\_ **Witness:** \_\_\_\_\_

## DENTAL TREATMENT CONSENT FORM

Please read and initial the items below

And read and sign the section at the bottom of form.

Patient Name \_\_\_\_\_

**1. Diagnostic and preventive (Initials \_\_\_\_\_)**

X-rays, Cleaning, Scaling

**2. Drugs and Medications (Initials \_\_\_\_\_)**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

**3. Nitrous Oxide (Initials \_\_\_\_\_)**

I understand that Nitrous oxide provides relaxation to make it more comfortable for me to receive the necessary dental care with less anxiety. I will be awake, fully conscious, aware of my surroundings, and able to respond rationally. I have informed the doctor of my complete medical history including any recent surgeries or changes in my medical history.

**4. Local Anesthetic (Initials \_\_\_\_\_)**

I understand there are risks of local anesthesia that may affect my body such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or various types of allergic reactions. It may also cause injury to nerves that can result in pain, numbness, tingling that may persist for several weeks, months, or rarely, be permanent. I have informed my doctor of my complete medical history including any recent surgeries or changes in my medical history.

**6. Removal of Teeth (Initials \_\_\_\_\_)**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.). 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. 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.

**7. Crowns and Bridges (Initials \_\_\_\_\_)**

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 or bridge (including shape, fit, size and color) will be before cementation.

**8. Dentures, Complete or Partial (Initials \_\_\_\_\_)**

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 fees.

**9. Endodontic Treatment (Root Canal) (Initials \_\_\_\_\_)**

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 posts are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally surgical procedures may be necessary following root canal treatment (apicoectomy).

10. We invite you to discuss with us any questions regarding our service. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information I have provided. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment by 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.

Signature of patient or legal guardian \_\_\_\_\_ Date \_\_\_\_\_

# Pennyrile Family Dentistry

Dr. Joseph N. Falco, IV

Dr. Ryan Vonnahme

Dr. Zachary Garnett

205 Burley Ave.

Hopkinsville, KY 42240

**Missed appointments.** Our policy is to charge for missed appointments not canceled within 24 hours. This charge of \$25 will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our missed appointments policy. Please let us know if you have any questions or concerns.

**I have read and understand the missed appointment policy and agree to abide by its guidelines:**

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Signature of patient or responsible party

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Date



**Dr. Joseph Falco, DMD**  
**Dr. Ryan Vonnahme, DMD**  
**Dr Zachary Garnett, DMD**  
**205 Burley Ave, Hopkinsville, KY 42240**  
**(270)632-6404 Phone (270) 632-4296 FAX**

## **NOTICE OF PRIVACY PRACTICES**

**Joseph Falco DMD, Ryan Vonnahme DMD, Zachary Garnett DMD**  
**Effective Date: February 16, 2026**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices supersedes all prior Notices of Privacy Practices and reflects current legal requirements and privacy practices.

### **CONTACT INFORMATION**

If you have questions about this Notice, our privacy practices, wish to obtain additional copies, or want to exercise your privacy rights, please contact our Privacy Officer:

**Privacy Officer / Office Manager: Tara Beaulieu**  
**Telephone: (270) 632-6404**  
**Fax: (270) 632-4296**  
**Email: [office@pennyrilefamilydental.com](mailto:office@pennyrilefamilydental.com)**  
**Address: 205 Burley Ave Hopkinsville, KY 42240**

### **OUR LEGAL DUTIES**

We are required by law to maintain the privacy of your protected health information ("PHI"), to provide you with this Notice of our legal duties and privacy practices, and to follow the terms of this Notice currently in effect. This Notice takes effect on the date listed above and remains in effect until it is replaced. We reserve the right to change our privacy practices and the terms of this Notice at any time, as permitted by law. Any changes will apply to all PHI we maintain, including information created or received before the changes were made.

If we make a material change to this Notice, we will provide you with a revised Notice. The revised Notice will be available at our office and on our website, and you may request a copy at any time.

We collect and maintain oral, written, and electronic health information to administer our business and provide dental care. We maintain appropriate physical, administrative, and technical safeguards to protect your PHI against loss, destruction, and unauthorized use or disclosure in accordance with federal and state law.

### **USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION**

#### **Treatment**

We may use or disclose your PHI without your authorization to provide, coordinate, or manage your dental care. This may include sharing information with dentists, specialists, hygienists, or other healthcare providers involved in your treatment (for example, referring information to an oral surgeon).

#### **Payment**

We may use or disclose your PHI to obtain payment for services provided to you. This may include submitting claims to dental or health insurance plans and providing necessary information to determine coverage or benefits.

#### **Health Care Operations**

We may use or disclose your PHI for healthcare operations, which include:

- Quality assessment and improvement activities
- Evaluating provider performance, qualifications, and competence
- Accreditation, credentialing, licensing, and training activities
- Audits, compliance reviews, and legal services
- Fraud and abuse detection and prevention
- Business planning, administration, billing, customer service, and complaint resolution
- De-identifying information or creating limited data sets as permitted by law.

## Pennyrile Family Dentistry Office Policies

Payment will be expected at the time of service for all non-contracted fees and co pays.

**Insurance contracts:** If we are in contract with your insurance carrier, we will accept assignment on all covered services and bill your carrier for you. You are responsible for the co pay, coinsurance, deductible, and for all non-covered services.

Insurance plans represent a contract between you and the insurance company. These contracts are not between the doctor and the insurance company. We will do our best to help you obtain benefits, but we cannot be responsible if your carrier does not pay. Further, if a member of our staff advises you that you are fully covered or implies that you will owe nothing, it is your responsibility to contact your insurance company for verification. Therefore, it is your responsibility to make certain your carrier makes prompt payment, and to handle any disputes that may arise.

Third party financing may be available through **CareCredit** for patients requiring extensive treatment. This type of financing must be approved in advance. Interest free financing is available for treatment plans over \$300. Extended plans are also offered for 24, 36, or 48 months with a fixed payment 9.9% APR. Please refer to the CareCredit brochure or ask a staff member for further details.

For appointments lasting longer than an **hour and a half**, we ask that you put **10%** down to reserve the doctor's time.

**If at any time you have questions regarding any treatment, fees, or services, please discuss them with us promptly. We will make every effort to avoid a misunderstanding, to rectify an injustice, and preserve a friendship.**

**Missed Appointments:** Cancellations must be called in within **24 hours** of appointment. Regretfully, repeated failure to make your appointments may result in your dismissal as a patient from Pennyrile Family Dentistry.

**Tardiness:** Please respect our time as we do yours. In the event that you are running late, we might have to reschedule your appointment due to our time constraints.

**Cellular Phones/pagers:** We request all cellular phones and pagers be turned off or put on silent mode during your appointment.

We reserve the right to dismiss any patient from our practice for inappropriate behavior while on the phone or in our office.

***I acknowledge that I am responsible to pay all charges for treatment administration by Pennyrile Family Dentistry as outlined above.***

Responsible Party Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

We may disclose PHI to another healthcare provider or health plan for their healthcare operations if they have or had a relationship with you and the information relates to that relationship.

## **OTHER USES AND DISCLOSURES**

### **Your Authorization**

You or your legal representative may authorize us in writing to use or disclose your PHI for purposes not described in this Notice. You may revoke your authorization at any time in writing, except to the extent we have already relied on it.

We will obtain your written authorization before using or disclosing your PHI for marketing purposes, fundraising communications, or any sale of PHI, as required by law. You may opt out of such communications at any time without affecting your care.

We also comply with applicable Kentucky privacy and confidentiality laws to the extent they provide greater protection than federal law.

### **Family, Friends, and Others Involved in Your Care**

We may disclose relevant PHI to a family member, friend, or other person involved in your care or payment for your care, unless you object. If you are not present, incapacitated, or in an emergency situation, we may use professional judgment to determine whether disclosure is in your best interest.

### **Appointment Reminders and Health-Related Communications**

We may use or disclose PHI to contact you about appointments, treatment alternatives, or other health-related benefits and services.

#### **Voicemail and Messages:**

Messages left will be limited to your name, our office name, and a call-back number. No detailed health information will be left unless you have requested our office to do so for a singular situation.

#### **Email Communication:**

By providing your email address, you acknowledge that email may not be a secure form of communication and agree that we may communicate with you via email, including appointment reminders and legally required breach notifications.

### **Appointment Communications**

We may contact you via phone, text message, email, or patient portal regarding appointment scheduling, upcoming or available appointments, and related administrative matters, in accordance with your selected communication preferences.

Appointment reminders are provided as a courtesy. Patients are responsible for remembering scheduled appointments and arriving on time. At a patient's request, electronic appointment reminders may be discontinued.

Missed appointments or appointments canceled with less than one (1) business days' notice may be subject to a fee. For additional details, please refer to our Patient Communications and Appointment Policy.

You may request alternative or confidential communication methods at any time.

### **Plan Sponsors**

If your dental coverage is provided through an employer-sponsored plan, we may disclose summary health information to the plan sponsor as permitted by law.

## **PUBLIC HEALTH AND LEGAL DISCLOSURES**

We may use or disclose your PHI without your authorization when required or permitted by law, including:

- Public health activities (such as reporting disease, abuse, or neglect)
- Preventing or reducing a serious and imminent threat to health or safety
- Health oversight activities (audits, investigations, licensure)
- Research activities as permitted by law.
- Judicial and administrative proceedings
- Law enforcement purposes

- Coroners, medical examiners, funeral directors, and organ donation organizations
- Military, national security, and correctional institution activities
- Workers' compensation claims

If another law provides greater privacy protection than HIPAA, we will follow the more stringent law.

## **NOTICE OF REDISCLOSURE**

If your health information is disclosed pursuant to a judicial or administrative process, including a court order, subpoena, or other lawful request, the recipient of such information **may be prohibited by law from further redisclosing the information** without your authorization or as otherwise permitted by law.

For records protected under **42 CFR Part 2**, federal law strictly limits redisclosure and may impose penalties for unauthorized use or disclosure.

## **BUSINESS ASSOCIATES**

We may disclose your PHI to business associates who perform services on our behalf (such as billing, IT support, or legal services). Business associates are required by contract to safeguard your PHI and comply with applicable privacy and security requirements.

## **DATA BREACH NOTIFICATION**

We may use your contact information to notify you, as required by law, of any unauthorized access, acquisition, or disclosure of your PHI.

## **ADDITIONAL PROTECTIONS FOR CERTAIN INFORMATION**

Certain federal and state laws provide additional protections for specific types of health information, **to the extent applicable**, including:

- HIV/AIDS-related information
- Mental health information
- Genetic information (GINA)
- Alcohol and substance abuse treatment information
- Sexually transmitted disease and reproductive health information
- Child or adult abuse or neglect information

Such information will be disclosed only as permitted by law.

## **CONFIDENTIALITY OF SUBSTANCE USE DISORDER (SUD) RECORDS (42 CFR PART 2)**

To the extent applicable, records relating to substance use disorder ("SUD") treatment that are protected under **42 CFR Part 2** are subject to additional confidentiality protections.

Such records may not be used or disclosed without your written authorization or as otherwise permitted or required by federal law. When permitted, disclosures of Part 2 records will be limited to the minimum necessary and will comply with all applicable federal confidentiality requirements.

You have additional rights regarding Part 2 records, including the right to revoke authorization and the right to receive an accounting of disclosures, as provided by law.

## **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

You have the right to:

1. **Inspect and obtain a copy** of your health records, including an electronic copy if maintained electronically.
2. **Request an amendment** to your health information.
3. **Receive an accounting of disclosures** made in the past six (6) years, excluding certain permitted disclosures.
4. **Receive a copy of this Notice** at any time.
5. **Request restrictions** on uses or disclosures of your PHI. We must comply with requests to restrict disclosure to a health plan if you pay for a service in full out-of-pocket.

6. **Request confidential communications**, such as alternative addresses or phone numbers.
7. **Choose whether to authorize** certain uses or disclosures, including marketing and fundraising.
8. **Opt out of fundraising communications** at any time.
9. **File a complaint** if you believe your privacy rights have been violated.

## REPRODUCTIVE HEALTH INFORMATION

We do not use or disclose protected health information related to reproductive health care for purposes prohibited by federal law.

We will not use or disclose reproductive health information for the purpose of investigating or imposing liability on a person for seeking, obtaining, providing, or facilitating lawful reproductive health care.

When required by law to disclose information related to reproductive health care, we will comply only with valid legal requirements and will limit disclosures to the minimum necessary as required by federal law.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with:

### U.S. Department of Health and Human Services

Office for Civil Rights  
200 Independence Avenue, SW  
Washington, DC 20201  
**Phone:** 1-800-368-1019

We will not retaliate against you for filing a complaint.

## NOTICE OF PRIVACY PRACTICES

### Acknowledgment of Receipt

- I acknowledge that I have received a copy of the **Notice of Privacy Practices for Pennyrile Family Dentistry/Joseph Falco DMD, Ryan Vonnahme DMD, Zachary Garnett DMD**, effective **February 16, 2026**.
- I understand that this Notice describes how my protected health information may be used and disclosed and how I can access this information.

**Patient Name (Print):** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If signed by a personal representative:

**Representative Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

### OFFICE USE ONLY

**Patient refused to sign**

notice was provided and explained on: \_\_\_\_\_ Staff who provided notice: \_\_\_\_\_