R.T. Foust IV, DDS, PLLC

— General Dentist Providing Oral Surgery Services —

at Crabtree Dental 23056 Westheimer Parkway, Katy, Texas 77494

281.347.1960(office) 832.600.6878(cell) rfoust@rfoustdds.com www.rfoustdds.com

PRE-OPERATIVE INSTRUCTIONS FOR DENTAL SURGERY

**** VERY IMPORTANT INFORMATION—PLEASE READ CAREFULLY ****

**** COMPLETE ATTACHED "MEDICAL HISTORY UPDATE FORM" ****
& RETURN IT TO YOUR DENTIST PRIOR TO SURGERY

1. If you have any concerns or questions about the surgery, please contact Dr. Foust at 832.600.6878 or by email at rfoust@rfoustdds.com.
2. I will be reviewing your medical history with you immediately prior to the surgery. Please be sure you are familiar with that information—especially with the name(s) and dosage(s) of any medications you are taking. If you feel your history is relatively complicated, we will need to decide if a consultation with your physician is necessary before the procedure is performed.
3. Patients who are minors (under 18 years of age) must have a legal guardian present to both fill out the "Medical History Update Form" and to sign the "Disclosure and Consent Form."
4. It is important to avoid smoking for at least one week before the surgery and one week following the surgery.
5. Keep in mind that it is best to allow for some flexibility around your appointment time on the day of your surgery. It is best not to "squeeze in" an appointment for surgery on an already busy day.

If you are having IV (intravenous) conscious sedation:

1. To reduce the chances of nausea, do not eat or drink anything (including water) for *at least six hours prior to your appointment*.
   - If your surgery is in the morning, do not eat or drink anything between bedtime and your scheduled appointment.
   - If your surgery is in the afternoon, a light breakfast before 7:00 a.m. is encouraged.
   - Unless specified by your dentist, all medicines taken on a routine basis should be continued without interruption. Please swallow with a minimal amount of water.
2. **A responsible adult, over 18 years of age, should accompany you to the office and should *remain in the office during the entire procedure*. Following the sedation, this responsible adult should be physically capable of assisting and accompanying you home and should remain with you for the next 24 hours.**
3. If receiving intravenous sedation, you should wear clothing, which is not restricting to the neck or arms. You should wear loose-fitting tops on which the sleeves can be rolled up to the shoulder. Also, please be sure to wear shoes that are securely fastened; no flip-flops or loose-fitting sandals, please.
4. Following the sedation, you should refrain from driving an automobile or engaging in any activity that requires alertness for the next 24 hours.
5. There are important differences between general anesthesia (being completely asleep) and IV conscious sedation. If you have any questions about the IV conscious sedation process, please feel free to contact Dr. Foust at 832.600.6878 prior to the procedure.

NOTE: Additional pre-operative information can be found at *www.rfoustdds.com*.
I recommend you preview the "Disclosure and Consent Form" on the website,
or you can request a copy from your dentist

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POST-OPERATIVE INSTRUCTIONS FOLLOWING DENTAL SURGERY

THINGS TO EXPECT RIGHT AFTER SURGERY:

After surgery, the patient's post-operative ride will be shown how to change the gauze and will be given post-operative irrigation instructions. Extra gauze will also be provided for the patient to take home. Most patients will only need to keep the new gauze in place for 1-1.5 hours. It is recommended that the patient firmly bite down, putting pressure on the gauze, while NOT TALKING. Ultimately, the longer a patient firmly bites down, with pressure on the gauze, waiting for the clot to establish before eating or drinking, the less chance they will have of swallowing blood. Swallowing blood can cause nausea and vomiting. The sooner a patient eats or drinks right after a surgery, the more a surgery site will bleed. Patient may have cold and creamy food typically between 1-1.5 hours after surgery. Contact 911 or Emergency Medical Services (EMS) if patient loses or has lost consciousness.

DO'S

1. DO eat only cold and creamy foods the day of surgery until the numbness wears off, which can take several hours (in some cases up to 18 hours). Eating hot foods or soups while patient is still numb can dislodge blood clots and can burn the mouth.
2. DO eat liquid/mushy foods for 14 days. Liquid/mushy foods are foods you can swallow without chewing, such as: smoothies, mashed potatoes, pudding, yogurt, Ensure, protein drinks, milkshakes, and applesauce.
3. DO use a spoon for eating; no straws/no spitting.
4. DO have the patient to read these instructions after surgery, as well as on the day after surgery. The patient will likely forget much of what happens on the day of surgery (including what is read) until after they awaken from a post-surgery nap later in the day.
5. DO eat 20 minutes prior to taking any pain medication or antibiotics in order to help prevent nausea.
6. DO rest for the first 24-48 hours after surgery. Patients who have sedation should refrain from driving an automobile or from engaging in any task that requires alertness for the first 24 hours after surgery.
7. DO take antibiotics, if prescribed. Be sure to *take all pills in prescription, as directed.*
8. DO expect swelling, pain, and discomfort to peak on days 3, 4, and 5. After day 5, the extraction site(s) should slowly decrease in discomfort every 2 days. For example, day 7 should feel a little better than day 5, and day 8 should feel a little better than day 6, etc.
9. DO return to your general dentist's office in five-to-seven days for your post-op appointment.
10. DO contact Dr. Foust at 832.600.6878 if swelling is excessive, spreading, or continuing to increase after 60 hours; if allergic reactions to medications occur that are causing a generalized rash or excessive itching; or, if things are not improving week by week.
11. DO begin using the irrigation syringe starting on day 5 after surgery. If you were prescribed Peridex, you will start swishing with it the day after the surgery, but you will also use it for irrigating with the syringe (you may dilute the Peridex with water when using it as an irrigation solution). When you run out of Peridex, start using watered down Listerine, mixing it with 50% water. Dr. Foust does not recommend a refill for Peridex because it may start to stain the patient's teeth. BLEEDING AFTER IRRIGATION IS NORMAL for the next several days, when you begin irrigation on day 5 after surgery.
    Irrigation Instructions: Begin irrigation 5 days after surgery. Curved tip of syringe MUST go in at least 1/3 of the way into the incision or hole left behind where the tooth was once positioned. For wisdom tooth patients, the incision or hole will be located behind the back remaining tooth in each arch between the tooth and the cheek. Solution from irrigation syringe should be pushed with enough force to empty it into the hole. It may help to take Ibuprofen (Advil) 30-40 minutes before patient starts the irrigation.
12. DO USE IRRIGATION SYRINGE STARTING DAY 4 OR 5 AFTER SURGERY, COMPLETING 2 SESSIONS PER DAY (one session in the afternoon/one session in the evening before bed). Express 7-8 syringes full of diluted solution (50% mouth rinse + 50% water) in each site for next several weeks until incisions or holes close. **Important:** Pain will peak 3-5 days after surgery, plateauing around day 5. If patient feels that pain has been tolerable but then suddenly begins to worsen, in an overwhelming majority of cases, this means that there is impacted food in the extraction site(s). In this case, patient should start to irrigate the holes as soon as the 4th day after surgery. ***NOTE:*** ***Each extraction site is its own, individual surgery site. For example, if you have had 4 wisdom teeth removed, it is common for one site (typically a lower site) to hurt more than the other 3 sites during the healing process.***

Science has proven that staggering between Ibuprofen (Advil) and Acetaminophen (Tylenol)
provides the greatest pain management for post-operative pain after tooth extractions.

Helpful How-to's for Taking Medications:

Stagger between Advil and Tylenol every 6 hours. Take Advil, and wait 3 hours...then, take 1-2 extra strength Tylenol tablets... then, wait 3 hours and switch back to Advil...then, wait 3 more hours, and switch back to Tylenol.

Advil (Ibuprofen) 600-800 mg = 3-4 over-the-counter pills ⇨ *Do NOT take more than 3200mg of Advil/Ibuprofen per day*

PLUS

Tylenol (Acetaminophen) 500-1000 mg = 1-2 extra strength pills ⇨ *Do NOT take more than 3000 mg of Tylenol/Acetaminophen per day*

DON'TS

1. DON'T hesitate to call Dr. Foust at 832.600.6878 if things aren't improving week-by-week or if surgery site PAIN doesn't slowly start to return to normal within 2 weeks.
2. DON'T change-out gauze all day long.
3. **DON'T sleep, eat, or drink with gauze in your mouth. THIS IS A CHOKING HAZARD!**
4. DON'T leave the patient alone for the first 24 hours—especially with gauze in his/her mouth.
5. DON'T allow patient to drive on the day of surgery.
6. DON'T chew while eating for 14 days.
7. DON'T smoke, vape, or drink alcohol for two weeks, and do not use smokeless tobacco (dip) for at least one month.
8. DON'T exercise hard for 4 full days.
9. DON'T blow your nose or hold in a sneeze for 7 full days.
10. DON'T miss or skip your post-op appointment 5-7 days after surgery.

For additional information, check-out our post-operative videos online at:

www.rfoustdds.com ➔ Click-on "Watch Our Videos"

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MEDICAL HISTORY UPDATE FORM

Name_____ Date_____
Last First Middle

Ht_____ Wt_____ Date of Birth____/____/____ Dentist's Name_____

If you are completing this form for another person, what is your relationship to that person?_____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire, and there may be additional questions concerning your health.

1. Are you in good health? ..... Yes No
2. Has there been any change in your general health within the past year? ..... Yes No
3. My last physical examination was on_____
4. Are you now under the care of a physician? ... Yes No
   If so, for what condition? _____
5. The name and address of your physician is:

   _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes No
7. Do you have any surgical/anesthesia history? . Yes No
   If yes, explain_____
8. Does your family have any surgical/anesthesia history?
   If yes, explain_____ Yes No
9. Are you taking any medicine(s), including non-prescription medicine(s)? ..... Yes No
   If so, what medicine(s) are you taking?_____

   _____
10. Have you ever taken Aredia, Zometa, Reclast, Fosamax, Actonel, Binosto, Atelvia, or Boniva? ..... Yes No
11. Do you have or have you had any of the following diseases or problems?
    a. Damaged or artificial heart valves, heart murmur, or rheumatic heart disease ..... Yes No
    b. Cardiovascular disease, angina, heart attack, heart trouble, stroke ..... Yes No
    c. Osteoporosis..... Yes No
    d. Cancer requiring IV chemotherapy ..... Yes No
    e. Asthma or hay fever ..... Yes No
    f. Fainting spells or seizures ..... Yes No
    g. Diabetes..... Yes No
    h. Hepatitis, jaundice, or liver disease ..... Yes No
    i. AIDS or HIV infection ..... Yes No
    j. Thyroid problems ..... Yes No
    k. Respiratory problems, bronchitis, etc. .... Yes No
    l. Sleep apnea or snoring during sleep ..... Yes No
    m. Stomach ulcer or hyperacidity..... Yes No
    n. Kidney trouble..... Yes No
    o. High or low blood pressure ..... Yes No
    p. Sexually transmitted disease..... Yes No
    q. Epilepsy/other neurological disease?..... Yes No
    r. Problems with the spleen..... Yes No
12. Have you had abnormal bleeding?..... Yes No
    Or required a blood transfusion?..... Yes No
13. Do you have any blood disorder, such as anemia? ..... Yes No
14. Have you been treated for a tumor? ..... Yes No
15. Do you smoke or vape? ..... Yes No
16. Are you allergic or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or other antibiotics..... Yes No
    c. Sulfa drugs..... Yes No
    d. Barbiturates, sedatives, sleeping pills..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine..... Yes No
    g. Codeine or other narcotics..... Yes No
    h. Other_____

Women

17. Are you pregnant?..... Yes No
18. Do you have any menstrual problems? ..... Yes No
19. Are you nursing?..... Yes No
20. Are you taking birth control pills? ..... Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. If your medical history is complex or if you feel you would like to provide us with additional information, it would be helpful for us if you would use the back of this form to write out a chronological narrative of your medical history.

_____
Signature of Dr. Foust

_____
Signature of Patient (or Patient's Guardian)

**** RETURN THIS COMPLETED FORM TO YOUR DENTIST PRIOR TO SURGERY ****

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DISCLOSURE AND CONSENT—DENTAL AND ORAL SURGERY

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and about the recommended surgical, medical, or diagnostic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you can give or withhold your consent to the procedure.*

I voluntarily request R.T. Foust IV, DDS, PLLC and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my condition which has been explained to me as:

Non-restorable, periodontally-involved, and/or impacted teeth _____

I(we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me(us), and I(we) voluntarily consent and authorize these procedures under local anesthesia supplemental by:_____Nitrous Oxide_____IV Sedation_____Oral Sedation

Surgical extraction of teeth _____

I(we) understand that my doctor may discover other or different conditions which require additional or different procedures than those planned. I(we) authorize my doctor and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

I(we) understand that no warranty or guarantee has been made to me as to result or cure. I(we) have been given both oral and written post-operative instructions, and I(we) agree to personally contact Dr. Foust in the event I(we) have a problem. I(we) will follow his instructions until that problem has been satisfactorily resolved. I(we) realize that in the event I(we) develop certain complications, I(we) may miss school or work schedules or I(we) may incur additional, unexpected expenses, including, but not limited to, expenses for other dentists, doctors, or medical facilities.

I(we) understand Dr. Foust is not employed by my dentist but is an independent contractor and will receive a portion of the fee paid to my dentist for these services. I(we) have chosen Dr. Foust from the alternatives I(we) have been offered to perform my dental surgery. I(we) understand that Dr. Foust is a general dentist.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I(we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, pain, swelling, bleeding, bruising, allergic reactions, cardiac arrest, brain injury, and even death. I(we) also realize that the following risks and hazards may occur in connection with this particular procedure:

_____1. Temporary or permanent nerve injury resulting in altered sensations or numbness of the lips, chin, tongue, teeth, and/or gums.

_____2. Damage to adjacent teeth and/or dental restorations.

_____3. Soreness at injection sites and/or along veins, as well as discoloration of the injection sites, face, and/or jaws.

_____4. Opening of the sinus requiring additional treatment.

_____5. Jaw fracture, muscle spasms, and/or limited opening of jaws for several days or weeks.

_____6. Small root fragments remaining in the jaw due to an increased possibility of surgical complications.

_____7. Jaw joint (TMJ) tenderness, soreness, pain, or locking, which may be temporary or permanent.

_____8. Other_____

I(we) understand that IV conscious sedation ("twilight sleep") and other forms of supplemental sedation involve additional risks and hazards, but I(we) request the use of IV conscious sedation and/or other forms of supplemental anesthesia to assist in the relief and protection from pain during the planned and additional procedures. I(we) realize the IV conscious sedation and/or other forms of supplemental anesthesia may have to be changed possibly without explanation to me(us). I(we) understand this is not general anesthesia (being completely asleep), and that it is unlikely, but I may have unpleasant memories of the procedure.

I(we) understand that certain complications may result from the use of any IV sedative or other form of anesthesia, including respiratory problems, drug reactions, paralysis, cardiac arrest, brain damage, or even death. Other risks and hazards which may result from the use of IV sedation or other sedatives or anesthetics range from minor discomfort to injury of the vocal chords, teeth, and/or eyes.

I(we) have been given an opportunity to ask questions about my(our) condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I(we) believe that I(we) have sufficient information to give this consent.

I(we) certify this form has been fully explained to me(us), that I(we) have read it or have had it read to me(us), that the blank spaces have been filled in, and that I(we) understand its contents.

I(we) consent to photographs of my oral and facial structures and of my patient documents regarding this procedure (for Dr. Foust's records).

Patient's Printed Name_____Time_____Date_____

Signature of Patient or Other Legally-responsible Person_____

WITNESS:_____DATE:_____

WITNESS:_____DATE:_____

SIGNATURE OF DR. FOUST:_____DATE:_____

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ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of R.T. Foust IV, DDS, PLLC's Notice of Privacy Practices effective 3/1/17.

Patient's Name (please print)_____

_____ _____

Signature of Patient Date Signed

****

I am a parent or legal guardian of (patient's name). I have received a copy of R.T. Foust IV, DDS, PLLC's Notice of Privacy Practices effective 3/1/17.

Parent or Legal Guardian's Name (please print)_____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

_____ _____

Signature of Parent or Legal Guardian Date Signed

I authorize the doctor and his staff to contact me by_____phone_____email_____mail *(check all that apply)*

****

If the patient or the patient's parent/legal guardian did not sign above, staff member must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and what efforts were used to obtain the signature.

Notice of Privacy Practices effective 3/1/17 given to individual on_____(date)

☐ In Person ☐ Email ☐ Mail ☐ Other_____

Reason patient or patient's parent/legal guardian did not sign this form:

☐ Did not want to sign
☐ Did not respond after more than one attempt
☐ Other_____

_____ _____

Staff Member's Name (please print) Title

_____ _____

Signature of Staff Member Date Signed

R.T. FOUST, IV, DDS, PLLC
— General Dentist Providing Oral Surgery Services —

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of R.T. Foust, IV, DDS, PLLC's ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Dr. R.T. Foust.
21715 Kingsland Blvd., #105 Katy, TX 77450-2544
E-mail: rfoust@rfoustdds.com Voice Mail: (832) 600-6878 Fax: (888) 565-5188

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:
•Maintain the privacy of your protected health information;
•Give you this Notice of our legal duties and privacy practices with respect to that information; and
•Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on 3/1/17

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our

practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate

in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is 3/1/17.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

R.T. Foust IV, DDS, PLLC

— General Dentist Providing Oral Surgery Services —

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SUPPLEMENTAL DISCLOSURE & CONSENT

INFORMATION FOR PATIENTS REGARDING POSSIBLE CHANGES IN SENSATIONS OF THE LIP, CHIN, OR TONGUE FOLLOWING DENTAL SURGERY

Dental surgery, like any other surgery, has certain inherent risks and limitations that may occur despite the experience and skill of the doctor. Following your surgery, it is possible that you may experience either temporary or permanent changes in the sensation or feelings of your lip, chin, or tongue. Permanent changes in sensation of the affected areas are extremely rare.

WHAT CAN CAUSE IT?

Because the nerves that supply these regions are close to the area where the surgery is performed, the nerves may not function normally for a while afterwards. These nerves affect sensation only and not movement.

The most common cause of this type of injury is from the pressure that can occur during either the removal of a tooth root or by the placement of an implant in the lower jaw. Occasionally, hooks or curves on the root may tear some of the nerve fibers. Another possible cause of injury is during the administration of the local anesthesia (numbing medicine). X-rays are helpful but cannot tell us the exact location of the important structures. When the nerve is especially close to the site of the surgery, it could be nicked or cut. Additionally, the incidence and severity of nerve injuries increases with age. This is particularly true for lower wisdom teeth. Further, sometimes sensation is affected without knowing exactly what caused it.

HOW LONG WILL IT LAST?

The likelihood that a change in sensation will occur and how long it will last can depend on many factors, including position of the tooth, the nerve, or the difficulty of the procedure. The duration of the condition is unpredictable and different in each case. It may last a few days, weeks, or months, and in very rare instances, may be permanent. In the majority of cases, the sensory loss gradually returns to normal although you may not be aware of any immediate improvement. Nerve tissue is the slowest tissue in the body to heal, and it can be weeks or months before you notice significant improvements. Nonetheless, it is important for you to stay in touch with us, so we may advise you of your specific circumstances.

HOW CAN I TELL IF I AM GETTING BETTER?

During nerve recovery, you may notice changes such as tingling, as if a local anesthetic is wearing off. Other sensations may also be present. Do not be alarmed; this is often a positive sign. It is important for you to help us in recording any changes in your symptoms so that we may better answer your questions and advise you as to your prognosis.

WHAT IF IT DOESN'T GET BETTER? CAN ANYTHING BE DONE?

If there has been absolutely no improvement in six weeks, then depending on your case, microsurgical repair could be considered. We can further council you on this possibility, and you will be referred to a specialist who is experienced and knowledgeable in this area.

IN SUMMARY

Remember, in the overwhelming number of instances of altered sensation, all or most of the normal sensation will return. If residual symptoms do remain, the risks involved with surgical repair may not be warranted, in that spontaneous, post-operative recovery may take up to two years to occur. By keeping in close contact with us, we are better able to advise you throughout your recovery process to insure optimum results.

_____ _____ _____

Patient's Name (printed) Signature of Patient (or Patient's Guardian) Date

WITNESS:_____ DATE:_____

WITNESS:_____ DATE:_____

SIGNATURE OF DR. FOUST:_____ DATE:_____