Welcome to NorthStar Dentistry for Adults!
It is my pleasure to welcome you to our practice. My wife Natalie (my lead dental assistant for almost 20 years) and I wanted to create a place that felt more like home than that of a typical upscale dental office. From the antique oak mantle that I refinished to the leather chairs, the video fireplace and fish tank, and the fresh coffee and dailyr baked cinnamon raisin bread we hope you feel at home here too.

The name "NorthStar" was chosen to inspire and direct us to serve you.

Trust and Confidence
This is the foundation to our business—our entire team pledges to treat our patients as family—we want to get to know you and how to best help you put your concerns and health first.

Caring—Health
Our tagline with our logo. Over 3 decades providing healthcare to thousands taught me that there is a big difference between "healthcare" and truly experiencing "caring" and "health".

Artistry
My advanced training at University of Michigan, Case Western, Marquette, University of Texas, University of Detroit, LSU, Tufts, and many Institutes as well as being one of less than 400 dentists worldwide Accredited by the American Academy of Cosmetic Dentistry provide you with true artistry and predictable results. I have networked with some of the country's most talented dental technicians to give you the best in esthetic results and longevity.

Your time is important
Our hours are Monday through Friday. We have appointments as early as 7am and as late as 5pm.

My hope is that you will be more than happy that you selected our office and made it your dental "home". That you will be so pleased that you will also refer your family and friends to seek care here.

Thank You for choosing NorthStar Dentistry for Adults!

Warmest Regards

John A Merrill, DDS, AACD

Dr. John A. Merrill, DDS, Accredited Member of the American Academy of Cosmetic Dentistry
9735 Kincey Ave, Ste. 206, Huntersville, NC 28078 PH: 704-450-6500 FX: 704-274-5484
Email: info@northstardentistryforadults.com Website: www.northstardentistryforadults.com

Website: **www.northstardentistryforadults**.com
9735 W KINCEY AVE, STE 204, HUNTERSVILLE, NC 28078
Phone: 704-450-6500

PATIENT INFORMATION

DATE_____

FIRST NAME_____LAST NAME_____

PATIENT'S Date of birth_____SS#_____

IF CHILD PARENT OR GUARDIAN'S NAME_____

ADDRESS 1_____

ADDRESS 2_____

CITY_____STATE_____ZIP _____

HOME PHONE_____CELL_____

BEST METHOD OF CONTACTING YOU:_____

REFERRED BY:_____

Why did you choose Dr. Merrill as your dentist?_____

Has any member of your family been treated in our office previously? ---------- Yes/ No If yes, Relationship_____

PLEASE CIRCLE—SINGLE MARRIED DIVORCED WIDOWED

Responsible person for account: SELF
OTHER: PLEASE LIST:_____SS#_____

Emergency Contact Information:
Name_____Relationship_____

Contact Number:_____

NORTHSTAR
DENTISTRY FOR ADULTS
CARING + HEALTH + ARTISTRY

DENTAL HISTORY

Are you currently having dental discomfort? If yes, explain: Yes/No

The most important concerns regarding my dental health are:_____

Please list any additional concerns or comments: _____

Dental Health (Please circle one) Excellent Good Fair Poor

What priority do you give your teeth (10 being the highest) 1 2 3 4 5 6 7 8 9 10

Please Circle:
Do you have any missing teeth? ----------Yes / No
Have missing teeth been replaced?----------Yes/ No
Orthodontic appliances now or in the past?----------Yes/ No
Gums bleed when brushing or flossing? ----------Yes/ No
Are you concerned about gum disease? ----------Yes/ No
Any history of gum disease? ----------Yes/ No
Does it hurt to bite or chew? ----------Yes/ No
Do you clench or grind your teeth?----------Yes/ No
Do you want your mouth properly restored and pain free?----------Yes/ No

Do you have any concerns about the appearance of your teeth?_____

Please circle one:

1. A) I think the appearance of my mouth is excellent.
   B) I am satisfied with the appearance of my mouth.
   C) I am dissatisfied with the appearance of my mouth.

2. A) I will do anything to keep my natural teeth.
   B) I want to keep my natural teeth, but have a certain budget of time and money that I am willing to spend on them.
   C) I don't care whether I keep them or not.

3. A) I have set goals for my oral health with a previous dentist.
   B) I want to set goals concerning my dental health.
   C) I have never set goals concerning my oral health.

4. A) I do exactly what is recommended for my dental health.
   B) I have done what dentists have recommended for my mouth.
   C) I rarely go and don't care much about having my dental work completed.

What will be the most important factors for your satisfaction with our office?

PREVIOUS DENTAL OFFICE INFORMATION:

Dentist Name_____

Practice Name_____PracticePhone#_____

Date of last Panoramic X-ray _____

Date of last Bitewing X-ray 4flm _____

Signature_____Date_____

NORTHSTAR
DENTISTRY FOR ADULTS
CARING + HEALTH + ARTISTRY

MEDICAL INFORMATION

DATE_____

MEDICAL HISTORY:

Primary Care Physician's Name _____

Practice Name _____PhoneNumber_____

Are you currently under a physician's care ----------Yes / No
Have you been hospitalized in the last 5 years?----------Yes / No
Any serious illnesses or surgeries ----------Yes / No
Do you use tobacco in any form? Yes/ No If yes, explain: _____

Do you have to pre-medicate before your dental appt due to heart condition or artificial joints?-----Yes/No if yes, what medication do you take and dosage _____

Do you know of any reason why routine dental procedures might post a risk to you, our staff, or other patient's? ---Yes/ No If yes, explain:_____

If there is any important medical condition(s) we need to be aware of please describe:

Are you taking any prescription or daily OTC medications/drugs?—Yes/ No
If yes, List in Medication Section

L PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ ACID REFLUX	☐ BULIMIA	☐ HEARING PROBLEMS	☐ PSYCHIATRIC TREATMENT
☐ ADHD	☐ CANCER/MALIGNANCY	☐ HEART ATTACK	☐ RADIATION/CHEMO
☐ AIDS/HIV	☐ CEREBRAL PALSY	☐ HEART DISEASE	☐ RESPIRATORY DISEASE
☐ ANEMIA	☐ CHEMICAL DEPENDENCY	☐ HEART MURMUR	☐ RHEUMATIC FEVER
☐ ANOREXIA	☐ CHICKEN POX	☐ HEPATITIS	☐ SINUS PROBLEMS
☐ ANXIETY	☐ CONVULSIONS	☐ HIGH BLOOD PRESSURE	☐ STROKE

]Artificial Heart Valve
]Artificial Joints
]Arthritis
]Asthma
]Autism/Asperger's
☐Depression
☐Diabetes
☐Dizziness/Fainting
☐Epilepsy/Seizures
☐Frequent Ear Infections
☐Kidney Disease
☐Liver Problems
☐Mitral Valve Prolapse
☐Mononucleosis
☐Pacemaker
☐Thyroid Condition
☐Tuberculosis
☐Ulcers
☐Venereal Disease

MEDICATION INFORMATION

ll Patients: Are you currently taking any of the following? (Check all that apply):

☐None

]Antibiotics/Sulfa Drugs
]Blood thinners
]Insulin
]Other Diabetic Medications
]Other (please list below)
☐Antihistamines/Allergy
☐Cancer/Chemo Medications
☐Nitroglycerin
☐Recreational Drugs
☐Daily Aspirin
☐Cortisone/Steroids
☐Oral Contraceptives
☐Thyroid Medications
☐Blood pressure Medications
☐Heart Medication/Digitalis
☐Osteoporosis Medications
☐Tranquilizers

)rug Name	**Dosage**	**Reason Prescribed**

]Bleeding Disorder
☐ Frequent Headaches
☐Other – please list:

ll Patients: Are you ALLERGIC to or have you ever had any reaction to the following? (Check all that apply):

☐None

]Aspirin
]Anesthetic – Local
]Barbiturates
]Other – please list:
☐Codeine
☐Dairy
☐Latex
☐Lactose Intolerance
☐Metal Sensitivity
☐Nitrous Oxide Sedation
☐Sleeping Pills
☐Sulfa Drugs
☐Penicillin/Other Antibiotics

NORTHSTAR
DENTISTRY FOR ADULTS
CARING + HEALTH + ARTISTRY

INSURANCE INFORMATION

EMPLOYMENT INFORMATION:

EMPLOYER'S
NAME:_____PHONE:_____

PRIMARY INSURANCE INFORMATION:

SUBSCRIBER'S EMPLOYER_____

INSURANCE CARRIER NAME_____

INSURANCE CARRIER PHONE#_____ GROUP #_____

SUBSCRIBER'S NAME_____

SUBSCRIBER'S DATE OF BIRTH _____

SUBSCRIBER'S ID NUMBER (this could be a SS#) _____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD DEPENDENT OTHER

SECONDARY INSURANCE INFORMATION:

SUSCRIBER'S
EMPLOYER_____PHONE:_____

INSURANCE CARRIER NAME_____

INSURANCE CARRIER PHONE#_____ GROUP #_____

SUBSCRIBER'S NAME_____

SUBSCRIBER'S DATE OF BIRTH _____

SUBSCRIBER'S ID NUMBER (this could be a SS#) _____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD DEPENDENT OTHER

SIGNATURE_____DATE:_____

NORTHSTAR
DENTISTRY FOR ADULTS
CARING + HEALTH + ARTISTRY

PHOTOGRAPHY RELEASE

I, _____,

hereby authorize NorthStar Dentistry For Adults to take photographs and/or videos of my face, jaws, mouth, and teeth.

I understand that the photographs and/or videos will be used as a record of my care, and may be used for educational purposes in study clubs meetings, lectures seminars, demonstrations, and professional publications (journals, magazines).

I further understand that if the photographs, slides, and/or videos are used in any publication or as part of a demonstration, my name or other identifying information will be kept confidential.

I will allow NorthStar Dentistry For Adults to photograph and use for educational purposes any aspect of my dental conditions or treatment procedures, and further will allow them permission to discuss my conditions with my physician and to request medical information from my physician.

I do not expect compensation, financial or otherwise, for the use of these photographs.

SIGNATGURE_____

DATE_____

NORTHSTAR
DENTISTRY FOR ADULTS
CARING + HEALTH + ARTISTRY

FINANCIAL GUIDELINES

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **We are in network for Aetna, Ameritas, Assurant/DHA, Delta Dental Premier, and PPO, Guardian, Humana, Metlife, Cigna Radius, United Concordia, United Healthcare**

- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered –**
-
- **Payment Information:**
  - **All major credit cards are accepted (Visa, MasterCard, Discover, American Express,)**
  - **5% Discount for our uninsured cash/check paying patients; payment must be made at time of service.**
  - **Various financing options with CareCredit®**
  - **Compassionate Healthcare Services**

- **Balances left over 90 days will incur a monthly late fee of 1/12% interest.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Short Cancelled/ Missed Appointments

- **Please give 48 hours notice** if you are unable to keep your reserved time. Our goal is to honor your time by staying on time unless there is an emergency—we sincerely ask our patients to honor our time as well.

.

By signing below I acknowledge I have read and understand the guidelines above.

Signature_____Date_____

NORTHSTAR
DENTISTRY FOR ADULTS
CARING + HEALTH + ARTISTRY

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Purpose of Release: □ Ongoing Communications □ Copy of Records □ Legal or Insurance Review □ Authorized Representative's Request □ Other

NAME OF PATIENT FOR WHOSE INFORMATION IS TO BE RELEASED:

NAME_____DOB_____PH:_____

ADDRESS:_____City/State/Zip_____

EMAIL ADDRESS:_____

RELEASE INFORMATION: □FROM □TO

The Facility/Practice/Individual listed below is authorized to release my Health Information.

Physican/Dentist Name:_____
__
Practice Address:_____

Practice Email Address:_____

Practice Phone:_____

CHECK THE SPECIFIC INFORMATION TO BE RELEASED:
□ALL RECORDS AND DETAILS □ PANORAMIC X-RAY □BITEWINGS □PERIO CHART □CLINICAL NOTES

□OTHER_____

RELEASE HEALTH INFORMATION: □ TO □FROM

NorthStar Dentistry For Adults
DR. JOHN A. MERRILL, DDS
9735 W KINCEY AVE,
SUITE 204
HUNTERSVILLE, NC 28078
PH: 704.450.6500
EMAIL: info@northstardentistyforadults.com

□ RELEASE TO MYSELF AT ABOVE ADDRESS

PATIENT'S SIGNATURE_____DATE_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2014

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

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

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

Signature _____**Date:**_____

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

_____

_____

☐ I give permission for the following communications to be used by NorthStar Dentistry For Adults **(please check all that apply)** :

☐ Cell phone: ☐Text Message reminders permitted

☐ Home phone ☐ Work ☐ E-Mail:

☐ I am granting permission for NorthStar Dentistry For Adults to disclose their identity to anyone who may answer my home, work or cell phone.

☐ I am granting permission for NorthStar Dentistry for Adults to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None- please just ask for a call back

☐ Other (Please explain)

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments,
treatment, and billing of any dependent children and myself listed above:

PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

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

I hereby authorize payment directly to NorthStar Dentistry for Adults of the dental benefits otherwise payable to me.

I hereby authorize NorthStar Dentistry for Adults to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature_____Date_____

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.

This notice applies to all of the records of your care generated by this practice, whether made by this practice or an associated facility.

Under the Health Insurance Portability Accountability Act of 1996 (HIPAA), all medical records and other individually identifiable health information of which we have knowledge must be kept confidential. All personal health information used by us or disclosed by us is covered by this Act regardless of whether this personal health information is in electronic, oral, or paper form. Several new rights are granted to patients under this Act, allowing control over how your personal health information is used, how you can access it, and in some cases amend it.

We are required by law to maintain the privacy of your personal health information and to provide you with notice of our legal duties and privacy practices with respect to your personal health information.

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPAA.

This Notice of Privacy Practices is effective IMMEDIATELY.

We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

HOW YOUR HEALTH INFORMATION MIGHT BE USED

You will be asked to sign a consent form authorizing us to use and disclose your PERSONAL HEALTH INFORMATION for the following purposes, as defined under the Act:

• **TO PROVIDE TREATMENT**We will use your PERSONAL HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling

---

and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies, or other health care personnel providing you current and future treatment.

- **TO OBTAIN PAYMENT**We will include your PERSONAL HEALTH INFORMATION to obtain reimbursement for our provision of health care. We may include your health information with an invoice used to collect payment for treatment you receive in our office. We will include your health information on all insurance claims, both actual and pretreatment, that we send electronically or in the mail. Other instances for which we will include your health information are: determination your eligibility of insurance coverage; management of your insurance claims; collection activities; justification of charges; and disclosure to consumer reporting agencies.

- **TO CONDUCT HEALTH CARE OPERATIONS**Your PERSONAL HEALTH INFORMATION may be included in any activity related to covered functions in which we participate in the function of our office, such as conducting quality assessment activities; protocol development; case management; care coordination; certification and licensing processes; auditing functions, business management, and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; fundraising, and marketing for which an authorization is not required.

- **DISCLOSURES THAT ONLY YOU, THE PATIENT, CAN AUTHORIZE** Though it does not usually apply to the dental field and therefore our dental practice, disclosures of psychotherapy notes. Uses and disclosures of PRIVATE HEALTH INFORMATION for marketing purposes, including subsidized treatment communications. Disclosure that constitute a SALE of PRIVATE HEALTH INFORMATION, exceptions to this rule would be when your PRIVATE HEALTH INFORMATION is used for public research, treatment and payment purposes, sale of this dental practice, transfer of PRIVATE HEALTH INFORMATION to a Business Associate, and charging you for a copy of your own PRIVATE HEALTH INFORMATION, which we only do if we incur a large cost by providing you your information. Otherwise, we do not charge a fee for this service.

We may, without prior consent use or disclose your personal health information to carry out treatment, payment, or health care operations:

- Directly to you at your request;

- In patient reminders to remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow-up on your care and inform you of treatment options or services that may be of interest to you or your family;

- If we believe you are the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement;

- If we are required by Federal officials or military authorities to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device;

- If we are required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime or describe the person who committed the crime; in response to a court order, subpoena, warrant, summons, or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about a death we believe may be the result of criminal conduct; and about criminal conduct at the practice;

- If a medical examiner or coroner requests the information to identify a deceased person or determine the cause of death. We may also release medical information about patients of the practice to funeral directors as necessary to carry out their duties.

- If you are an inmate of a correctional institution or under the custody of a law enforcement official, and we are requested by such institutions. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- If you are involved in a lawsuit or a dispute, we may disclose information about you in response to a court or administrative order. This is particularly true if you make your health an issue. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our practice in any actual or threatened action.

- In an emergency treatment situation, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment, if we are require by law to treat you and attempts to obtain consent are unsuccessful, or if we attempt to obtain consent but are unable, due to barriers of communication, but we determine in our professional opinion that treatment is clearly inferred from the circumstances;

- To those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care;

- Pursuant to and in compliance with an authorization signed by you;

- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree to or prohibit or restrict the use or disclosure. This may be an oral agreement between us and may include a directory maintained at our facility containing specific information allowed by this Act; and

- If other than is stated above or where Federal, State, or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time. We may de-identify your personal health information by using codes or removing all individually identifiable health information. All other uses and disclosures will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice, and we will abide by that request. However, exception would be any actions already taken, relying on your authorization, prior to revocation notice. **PATIENT RIGHTS** Under HIPAA, you have the following rights with respect to your protected health information:

- You have the right to request restrictions on certain uses and disclosures of protected health information, including restrictions place upon disclosure to family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a requested restriction;

- **NEW** as of March 26, 2013, you have the right to restrict disclosures to your insurance company for any treatment or services that you have paid in full, out-of-pocket. You must make such a request in writing and provide it to our front desk staff that file your insurance claims. Your written request will be kept in your patient record.

- **NEW** as of March 26, 2013, you have the right to receive an electronic copy of any records that we keep in electronic format. Those records only include digital x-rays. But you may receive an electronic copy of those records. To

receive a copy, you must sign a record release request that will be kept in

your patient record.

- **NEW** as of March 26, 2013, you may opt out of any fundraising communications that we send to you, even though we have never held fundraising events.

- You have the right to receive confidential communications of your protected health information, either directly from us, or from us by alternative means, or from alternative location;

- You have the right to inspect and copy your protected health information. To inspect and copy your dental/medical record, you must submit your request in writing to our HIPAA Compliance Officer. Ask the front desk person for the name of the HIPAA Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request;

- You have the right to amend protected health information, however, this request, may be denied under certain circumstances;

- You have the right to receive an account of disclosures of your protected health information made by us to others for purposes other than treatment, payment, or healthcare operations in the six years prior to the date of the accounting request; and

- You have the right to obtain a paper copy of this notice from us. **CHANGES TO THIS NOTICE** We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. In addition, each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect. **COMPLAINTS** If you believe your privacy rights have been violated, you may file a complaint with the practice or the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you. **You will not be penalized for filing a complaint. Furthermore,** we are require by law to inform you if a breach of unsecured PRIVATE HEALTH INFORMATION has occurred. And we are required to report any breaches of unsecured PRIVATE HEALTH INFORMATION to the U.S. Department of Health and Human Services (HHS.)