



**HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION**

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Name of Healthcare Provider:** Kent Dental; 20511 N. Hayden Rd. Suite 150, Scottsdale, AZ 85255 / 480-994-5555 / FrontDesk@KentDental.com

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information.

All records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse.

I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

\_\_\_\_\_  
Signature of Patient or Legally Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name and Relationship of Legally Authorized Representative to Patient

\_\_\_\_\_  
Date

**PATIENT INFORMATION**

Date: \_\_\_\_\_  NEW PATIENT  UPDATE

Patient: \_\_\_\_\_

LAST FIRST MI PREFERRED TITLE  
 MALE  FEMALE  CHILD\*  STUDENT\*\*  SINGLE  MARRIED  DIVORCED  WIDOWED

\*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW: \_\_\_\_\_  
 PARENT/GUARDIAN NAME(S)

\*\*IF STUDENT, PLEASE COMPLETE:  FULL-TIME  PART-TIME  
 SCHOOL/LOCATION \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ Patient SSN: \_\_\_\_\_

Address: \_\_\_\_\_  
 ADDRESS LINE 1  
 ADDRESS LINE 2  
 CITY ST ZIP CODE

E-Mail: \_\_\_\_\_

Referral?  Yes  No Referred by: \_\_\_\_\_

HOME: \_\_\_\_\_  
 CELL: \_\_\_\_\_  
 OTHER: \_\_\_\_\_

**EMERGENCY INFORMATION**

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP Tel: \_\_\_\_\_

**MEDICAL INFORMATION**

GENERAL HEALTH:  EXCELLENT  GOOD  FAIR  POOR

Do you have a personal physician?  Yes  No

PHYSICIAN'S NAME Tel: \_\_\_\_\_

**EMPLOYMENT INFORMATION**

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**INSURANCE INFORMATION**

Subscriber: \_\_\_\_\_  
 LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: \_\_\_\_\_ Subscriber SSN: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_

Patient Relationship to Subscriber:  SELF  SPOUSE  CHILD  OTHER

**PRIMARY INSURANCE CARRIER:**

Group/Policy No.: \_\_\_\_\_ ID No.: \_\_\_\_\_

Address: \_\_\_\_\_  
 CITY ST ZIP CODE

TEL: \_\_\_\_\_  
 TOLL-FREE: \_\_\_\_\_  
 FAX: \_\_\_\_\_

**SECONDARY INSURANCE CARRIER:**

Group/Policy No.: \_\_\_\_\_ ID No.: \_\_\_\_\_

Address: \_\_\_\_\_  
 CITY ST ZIP CODE

TEL: \_\_\_\_\_  
 TOLL-FREE: \_\_\_\_\_  
 FAX: \_\_\_\_\_

**MEDICAL HISTORY**

YOUR CURRENT DENTAL HEALTH:  EXCELLENT  GOOD  FAIR  POOR

- Y  N Any hospitalization in the past 5 years? \_\_\_\_\_
- Y  N Any serious illnesses/surgeries? \_\_\_\_\_
- Y  N Use tobacco in any form? If Yes, Type: \_\_\_\_\_
- Y  N Use of recreational drugs? \_\_\_\_\_
- Y  N Is pre-medication required before dental visits due to heart condition or artificial joint? \_\_\_\_\_
- Y  N Do you or have you ever experienced discomfort in your jaw joint (TMJ / TMD)? \_\_\_\_\_
- Y  N Do you have sleep apnea? \_\_\_\_\_
- Y  N Have you had a sleep apnea study in the last 5 years? \_\_\_\_\_
- Y  N Do you snore? \_\_\_\_\_
- Y  N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS:  Y  N Currently nursing?  Y  N Currently pregnant? Due Date: \_\_\_\_\_

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients?  Y  N  
If yes, please describe: \_\_\_\_\_

Is there anything important about your medical condition we have not asked?  Y  N If yes, please describe: \_\_\_\_\_

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):  NONE

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> ABNORMAL BLEEDING      | <input type="checkbox"/> COLITIS                 | <input type="checkbox"/> HEART ATTACK               | <input type="checkbox"/> PSYCHIATRIC PROBLEMS |
| <input type="checkbox"/> ALCOHOL / DRUG ABUSE   | <input type="checkbox"/> CONGENITAL HEART DEFECT | <input type="checkbox"/> HEART DISEASE              | <input type="checkbox"/> RADIATION/CHEMO      |
| <input type="checkbox"/> AIDS/HIV+              | <input type="checkbox"/> CONVULSIONS             | <input type="checkbox"/> HEART MURMUR               | <input type="checkbox"/> RESPIRATORY DISEASE  |
| <input type="checkbox"/> ANEMIA                 | <input type="checkbox"/> DEPRESSION              | <input type="checkbox"/> HEART SURGERY              | <input type="checkbox"/> RHEUMATIC FEVER      |
| <input type="checkbox"/> ANOREXIA               | <input type="checkbox"/> DIABETES                | <input type="checkbox"/> HEPATITIS A / B / C        | <input type="checkbox"/> SINUS PROBLEMS       |
| <input type="checkbox"/> ANXIETY                | <input type="checkbox"/> DIFFICULTY BREATHING    | <input type="checkbox"/> HIGH BLOOD PRESSURE        | <input type="checkbox"/> SLEEP DISORDER       |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> DIZZINESS/FAINTING      | <input type="checkbox"/> HOSPITALIZED               | <input type="checkbox"/> STROKE               |
| <input type="checkbox"/> ARTIFICIAL JOINTS      | <input type="checkbox"/> EMPHYSEMA               | <input type="checkbox"/> KIDNEY PROBLEMS            | <input type="checkbox"/> THYROID CONDITION    |
| <input type="checkbox"/> ARTHRITIS              | <input type="checkbox"/> EPILEPSY/SEIZURES       | <input type="checkbox"/> LIVER PROBLEMS             | <input type="checkbox"/> TUBERCULOSIS         |
| <input type="checkbox"/> ASTHMA                 | <input type="checkbox"/> FREQUENT HEADACHES      | <input type="checkbox"/> MITRAL VALVE PROLAPSE      | <input type="checkbox"/> ULCERS               |
| <input type="checkbox"/> BLOOD TRANSFUSION      | <input type="checkbox"/> GLAUCOMA                | <input type="checkbox"/> PACEMAKER                  | <input type="checkbox"/> VENEREAL DISEASE     |
| <input type="checkbox"/> CANCER/CHEMOTHERAPY    | <input type="checkbox"/> HAY FEVER               | <input type="checkbox"/> OTHER – PLEASE LIST: _____ |   |

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

- |   |   |                                       |                               |
|---|---|---------------------------------------|-------------------------------|
| <input type="checkbox"/> ASPIRIN                    | <input type="checkbox"/> ERYTHROMYCIN     | <input type="checkbox"/> PENICILLIN   | <input type="checkbox"/> NONE |
| <input type="checkbox"/> CODEINE                    | <input type="checkbox"/> JEWELRY / METALS | <input type="checkbox"/> TETRACYCLINE |                               |
| <input type="checkbox"/> DENTAL ANESTHETIC          | <input type="checkbox"/> LATEX            | <input type="checkbox"/> SULFA        |                               |
| <input type="checkbox"/> OTHER – PLEASE LIST: _____ |   |                                       |                               |

**MEDICATION INFORMATION**

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):  NONE

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> ANTIBIOTICS/SULFA DRUGS    | <input type="checkbox"/> ANTIHISTAMINES/ALLERGY   | <input type="checkbox"/> DAILY ASPIRIN       | <input type="checkbox"/> BLOOD PRESSURE MEDICATIONS |
| <input type="checkbox"/> BLOOD THINNERS             | <input type="checkbox"/> CANCER/CHEMO MEDICATIONS | <input type="checkbox"/> CORTISONE/STEROIDS  | <input type="checkbox"/> HEART MEDICATION/DIGITALIS |
| <input type="checkbox"/> INSULIN                    | <input type="checkbox"/> NITROGLYCERIN            | <input type="checkbox"/> ORAL CONTRACEPTIVES | <input type="checkbox"/> OSTEOPOROSIS MEDICATIONS   |
| <input type="checkbox"/> OTHER DIABETIC MEDICATIONS | <input type="checkbox"/> RECREATIONAL DRUGS       | <input type="checkbox"/> THYROID MEDICATIONS | <input type="checkbox"/> TRANQUILIZERS              |
| <input type="checkbox"/> OTHER (PLEASE LIST BELOW)  |   |  |   |

DRUG NAME	DOSAGE	REASON PRESCRIBED

By signing below, I certify that the information above is accurate and complete to the best of my knowledge.

Signature: \_\_\_\_\_

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

**Welcome.** To better serve you, please take just a couple of minutes to answer the following questions.

**Please check any of the following problems that apply to you:**

- Sensitivity (hot, cold, or sweet)  
If so, which teeth?
- Headaches, earaches, neck pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen, or irritated gums
- Loose, tipped or shifting teeth
- Bad breath

**Do you have any of the following?**

- Dentures
- Partial dentures
- Periodontal (gum) treatments

**Please share the following approximate dates:**

Your last cleaning \_\_\_\_\_  
Your last oral cancer screening \_\_\_\_\_  
Your last complete x-rays \_\_\_\_\_

Who was your previous dentist?

Name: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
Phone: \_\_\_\_\_

Has your doctor told you that you require antibiotics before dental treatment?

YES  NO

Your current dental health is

Good  Fair  Bad

Do you like your smile?

YES  NO

Do your gums bleed?

YES  NO

How many times do you brush your teeth?

\_\_\_\_\_

How many times a week do you clean between your teeth? \_\_\_\_\_

Floss  Waterpik  Other

Does any aspect of having dentistry done make you nervous or scared?

YES  NO

**If you could change your smile, would you:**  
(please check all that apply)

- Make your teeth whiter
- Make your teeth straighter
- Close spaces between your teeth
- Replace black metal fillings with tooth colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

**On a scale of 1 to 5, with 5 being the highest reading:** (please circle the number that best applies)

How important is your dental health to you?

**1 2 3 4 5**

How would you rate your current dental health?

**1 2 3 4 5**

Where do you want your dental health to be?

**1 2 3 4 5**

**Please answer the following questions.**

What are the most important things to you about your smile?

If you could whiten your teeth, at a cost that any would could afford would you like to?

Why did you leave your previous dentist?

What is the most important thing to you about your dental visit today?

## Financial Guidelines

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, American Express and Discover. Outside financing is available upon request and approval.

Please note: returned checks will be subject to additional fees. In case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred.

### *Do You Have Insurance?*

- As a courtesy to you, we will help you process all your dental insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as we have estimated. Your insurance company and your plan benefit ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, not with your insurance company. Your insurance policy is a contract between you, your employer and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company by cash, check, MasterCard, Visa, American Express or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30 days from the time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be made responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health needs and welcome any questions you may have concerning our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

PATIENT Signature (Parent of Child)

Date:

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PATIENT NAME: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**MEDICAL HISTORY**

 YOUR CURRENT DENTAL HEALTH:  EXCELLENT  GOOD  FAIR  POOR      ADDRESS/PHONE UPDATE?  Y  N      INSURANCE UPDATE?  Y  N

- Y  N Any hospitalization in the past 5 years? \_\_\_\_\_  
 Y  N Any serious illnesses/surgeries? \_\_\_\_\_  
 Y  N Use tobacco in any form? If Yes, Type: \_\_\_\_\_  
 Y  N Use of recreational drugs? \_\_\_\_\_  
 Y  N Is pre-medication required before dental visits due to heart condition or artificial joint?  
 Y  N Do you or have you ever experienced discomfort in your jaw joint (TMJ / TMD)?  
 Y  N Do you have sleep apnea?  
 Y  N Have you had a sleep apnea study in the last 5 years?  
 Y  N Do you snore?  
 Y  N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

 FEMALE PATIENTS:     Y  N Currently nursing?       Y  N Currently pregnant?      Due Date: \_\_\_\_\_

 Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients?  Y  N  
 If yes, please describe: \_\_\_\_\_

 Is there anything important about your medical condition we have not asked?  Y  N If yes, please describe: \_\_\_\_\_

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

 NONE

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> ABNORMAL BLEEDING      | <input type="checkbox"/> COLITIS                 | <input type="checkbox"/> HEART ATTACK               | <input type="checkbox"/> PSYCHIATRIC PROBLEMS |
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| <input type="checkbox"/> ANXIETY                | <input type="checkbox"/> DIFFICULTY BREATHING    | <input type="checkbox"/> HIGH BLOOD PRESSURE        | <input type="checkbox"/> SLEEP DISORDER       |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> DIZZINESS/FAINTING      | <input type="checkbox"/> HOSPITALIZED               | <input type="checkbox"/> STROKE               |
| <input type="checkbox"/> ARTIFICIAL JOINTS      | <input type="checkbox"/> EMPHYSEMA               | <input type="checkbox"/> KIDNEY PROBLEMS            | <input type="checkbox"/> THYROID CONDITION    |
| <input type="checkbox"/> ARTHRITIS              | <input type="checkbox"/> EPILEPSY/SEIZURES       | <input type="checkbox"/> LIVER PROBLEMS             | <input type="checkbox"/> TUBERCULOSIS         |
| <input type="checkbox"/> ASTHMA                 | <input type="checkbox"/> FREQUENT HEADACHES      | <input type="checkbox"/> MITRAL VALVE PROLAPSE      | <input type="checkbox"/> ULCERS               |
| <input type="checkbox"/> BLOOD TRANSFUSION      | <input type="checkbox"/> GLAUCOMA                | <input type="checkbox"/> PACEMAKER                  | <input type="checkbox"/> VENEREAL DISEASE     |
| <input type="checkbox"/> CANCER/CHEMOTHERAPY    | <input type="checkbox"/> HAY FEVER               | <input type="checkbox"/> OTHER – PLEASE LIST: _____ |   |

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

 NONE

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> ASPIRIN                    | <input type="checkbox"/> ERYTHROMYCIN     | <input type="checkbox"/> PENICILLIN   |
| <input type="checkbox"/> CODEINE                    | <input type="checkbox"/> JEWELRY / METALS | <input type="checkbox"/> TETRACYCLINE |
| <input type="checkbox"/> DENTAL ANESTHETIC          | <input type="checkbox"/> LATEX            | <input type="checkbox"/> SULFA        |
| <input type="checkbox"/> OTHER – PLEASE LIST: _____ |   |                                       |

**MEDICATION INFORMATION**

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

 NONE

- |   |   |  |   |
|---|---|--|---|
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| <input type="checkbox"/> BLOOD THINNERS             | <input type="checkbox"/> CANCER/CHEMO MEDICATIONS | <input type="checkbox"/> CORTISONE/STEROIDS  | <input type="checkbox"/> HEART MEDICATION/DIGITALIS |
| <input type="checkbox"/> INSULIN                    | <input type="checkbox"/> NITROGLYCERIN            | <input type="checkbox"/> ORAL CONTRACEPTIVES | <input type="checkbox"/> OSTEOPOROSIS MEDICATIONS   |
| <input type="checkbox"/> OTHER DIABETIC MEDICATIONS | <input type="checkbox"/> RECREATIONAL DRUGS       | <input type="checkbox"/> THYROID MEDICATIONS | <input type="checkbox"/> TRANQUILIZERS              |
| <input type="checkbox"/> OTHER (PLEASE LIST BELOW)  |   |  |   |

DRUG NAME	DOSAGE	REASON PRESCRIBED

ADDRESS UPDATE: \_\_\_\_\_

PHONE UPDATE: \_\_\_\_\_

INSURANCE UPDATE: \_\_\_\_\_

By signing below, I certify that the information above is accurate and complete to the best of my knowledge.

Signature: \_\_\_\_\_

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



## PHOTO RELEASE FORM

I hereby authorize Kent Dental to publish the photographs and/or video taken of me, and my name, for use in Kent Dental's printed publications, newsletter releases, online, and in other communications related to the mission of Kent Dental. I acknowledge that since my participation in publications and other forms of media produced by Kent Dental, is voluntary and I will receive no financial compensation.

I further agree that my participation in any publications and other forms of media produced by Kent Dental confers upon me nor rights of ownership whatsoever. I release Kent Dental, its contractors and its employees from liability for any claims by me or any third party in connection with my participation.

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(Signature of Adult, or Guardian of Children under age 18)

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

Date \_\_\_\_\_

**Thank you!**



### **Cancellation and No-Show Policy**

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

We understand that situations arise that you are unable to control and are forced to cancel your appointment. We ask that you cancel your appointment as soon as you are aware your situation has changed and no less than 48 hours in advance. With cancellation less than 48 hours we are unable to fill the appointment with someone who is on our waiting list, resulting in lost time and production.

Office appointments which are canceled with less than 48 hours' notice are subjected to a \$50.00 cancellation fee.

The Cancellation and No-Show fees are the sole responsibility of the patient and will be due prior to your next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived or reduced but only with management approval.

Our practice firmly believes in a good doctor/patient relationship is based on understanding and good communication. Questions about cancellation and no-show fees should be directed to the billing department.

Please sign below acknowledging your understanding and agreement to our cancellation and no-show policy.

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date



## Privacy Policy

Effective Date: 9/29/2022

This Privacy Policy explains how Tuttle Shuttle collects, uses, and discloses personal information about our customers, prospective customers, and visitors to our website at [www.tuttleshuttle.org](http://www.tuttleshuttle.org). Information collected directly from you: We may collect personal information directly from you, for example. Personal information we collect directly from you may include. Information collected from your device: Our website may use technologies such as cookies, web beacons, pixels, and other similar technologies to automatically collect certain information from your device. Our website may also use cookies and similar technologies to enhance your user experience and enable certain features such as keeping track of items you put in your shopping cart. Our email campaigns may also use tracking technologies such as web beacons, pixels, and other similar technologies to automatically collect certain information such as your IP address, browser type and version, and email engagement statistics. through a web form, during registration, while making a reservation, while setting up an account with us when you contact us for customer support, or at checkout first and last name, address, email address, and phone number your IP address, date and time of your visit, browser and operating system information, referring website address, and other information about how you interact with the website Information collected from our partners: We may collect personal information about you from our third-party partners and combine it with other information that we collect. Personal information we collect from our partners may include, for example, your demographic information, shopping history, and geographic location.

We may use information collected about you for any lawful purpose, including the following:

To provide you with our products and services, customer service and support, and other relevant information. To market our products and services to you, including by email and text message subject to your consent. To provide our website to you, to optimize our website, and to assist with our advertising and marketing efforts. To send you abandoned cart reminders if you added items to your shopping cart but did not complete checkout.

- To comply with the law and to maintain the security of our website; or
- With your consent, or as otherwise disclosed at the time information is collected. We may share the information we collect with other parties, including the following:
  - With third-party service providers to assist us with providing and marketing our products and services,
  - With Constant Contact, to send email marketing and text message communications. For more information about how we may use your information with Constant Contact and the information that may be collected through our email campaigns, see Constant Contact's Customer Data Notice available at <https://www.constantcontact.com/legal/customer-contact-data-notice>.

Our website may also use cookies and similar technologies to enhance your user experience and enable certain features, such as keeping track of items you put in your shopping cart. Our email campaigns may also use tracking technologies such as web beacons, pixels and other similar technologies to automatically collect certain information such as your IP address, browser type and version, and email

engagement statistics. through a web form, during registration, while making a reservation, while setting up an account with us when you contact us for customer support, or at checkout first and last name, address, email address, and phone number your IP address, date and time of your visit, browser and operating system information, referring website address, and other information about how you interact with the website. Information collected from our partners: We may collect personal information about you from our third- party partners and combine it with other information that we collect. Personal information we collect from our partners may include, for example, your demographic information, shopping history, and geographic location.

We may use information collected about you for any lawful purpose, including the following:

To provide you with our products and services, customer service and support, and other relevant information. To market our products and services to you, including by email and text message subject to your consent. To provide our website to you, to optimize our website, and to assist with our advertising and marketing efforts. To send you abandoned cart reminders if you added items to your shopping cart but did not complete check out.

- To comply with the law and to maintain the security of our website; or
- With your consent, or as otherwise disclosed at the time information is collected.
- We may share the information we collect with other parties, including the following:
  - With third-party service providers to assist us with providing and marketing our products and services
  - With Constant Contact, to send email marketing and text message communications. For more information about how we may use your information with Constant Contact and the information that may be collected through our email campaigns, see Constant Contact's Customer Data Notice available at <https://www.constantcontact.com/legal/customer-contact-data-notice>.
  - With any affiliates or joint venture partners that we may have in the future.
  - As part of a corporate sale, merger, or acquisition, or other transfer of all or part of our assets, including as part of a bankruptcy proceeding.
  - If necessary to comply with applicable laws and regulations, to respond to a subpoena, search warrant or other lawful requests for information we receive, or to otherwise protect our rights or the rights of third parties, or to protect the safety or security of any person or entity.
- With your consent or as otherwise disclosed at the time of data collection or sharing.

We may share information that has been de-identified or aggregated without limitation. Our website may offer interactive features, such as the ability to leave reviews, that you can use to communicate with other website visitors or to submit and post your own content. If you disclose information in one of these forums, this information can be viewed, collected, and used by others. such as payment

processors, data hosting services, analytics services, online store support, advertising partners, and email service providers.

We may authorize our advertising partners to use cookies and similar technologies on our website to automatically collect certain information from your device, and we may share information about you, your purchases, and your interactions with our website and may also collect information from others with our advertising partners. These partners' websites or apps over time. Such information can be used by us or our advertising partners to serve more relevant targeted ads. For more information about this type of advertising and how to opt-out of targeted advertising from our advertising partners.

We may also work with third parties that collect data about your use of our website and other sites or apps over time for non-advertising purposes. We use Google Analytics and other third-party services to improve the performance of the website and for analytics and marketing purposes. For more information about how Google Analytics collects and uses data when you use our website, visit [www.google.com/policies/privacy/partners](http://www.google.com/policies/privacy/partners), and to opt-out of Google Analytics, visit [tools.google.com/dlpage/gaoptout](http://tools.google.com/dlpage/gaoptout).

Your web browser may allow you to block or disable cookies; however, parts of our website may not function properly if you do so.

#### **EMAIL AND TEXT MESSAGE COMMUNICATIONS**

If you wish to unsubscribe from our email campaigns, please click on the Unsubscribe link at the bottom of any marketing email sent from us. If you opt-out of our email marketing, we will still send you messages related to our transactions and relationship with you, such as order confirmations.

If you wish to stop receiving text messages from us, reply STOP, QUIT, CANCEL, OPT-OUT, or UNSUBSCRIBE to any text message sent from us. For more information, see our Mobile Messaging Terms and Conditions available at <https://files.constantcontact.com/3d1a4593901/9ab7088c-1f18-4ac5-99e9-d93045d04d08.pdf> relationships among different browsers and devices

When you have an account with us, you may review, change, or update your contact information by logging into your account.

#### **CHANGES TO THIS PRIVACY POLICY**

We may update this Privacy Policy at any time. Please review it frequently.

#### **CONTACT INFORMATION**

If you have any questions about this policy or our privacy practices, please contact us at (480) 660-3897.