Piedmont Regional Dental Clinic Patient Registration

Patient's First Name_____ MI____ **Last Name** _____

Preferred Name_____ **Date of Birth**____/____/____ Age_____

Marital Status (circle one) Single / Married / Widowed / Divorced / Child **Gender** (circle one) Male / Female / Other

Street Address_____ **City**_____ **State** _____ **County**_____**Zip**_____

P.O. Box_____ **City**_____ **State** _____ **County**_____**Zip**_____

Home Phone ( )_____Cell Phone ( )_____ Work Phone ( )_____

Email (required) _____ Is it ok to contact you and leave messages at the above numbers listed or email? YES / NO

Occupation_____ **Employer** _____

Responsible Party (if other than the patient) __ I affirm that that I have legal authority to provide consent for treatment for this patient.
Parent/Guardian Name_____ Phone ( )_____

Relationship _____

Are there children under 12 in your household? YES / NO
If yes, what school(s) do they attend? _____

PRDC in a non-profit organization. PRDC is required to report the following information. Please answer/circle.

Race: White Black/African American American Indian or Alaska Native Asian Native Hawaiian or Pacific Islander Other Unknown

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Veteran Status: YES / NO If yes, please ask about free care on Veterans Day.

Homeless Status: YES / NO If yes, please choose one: Doubling up Transitional Shelter Street

Would you like to know about PRDC's Affordable Care Program for income-eligible households? YES / NO

Emergency Contact Information: In case of an emergency, PRDC requires contact information for at least one person to be listed.

Name_____ Relationship_____Phone ( ) _____

Medicaid covered patients: ID Number (12 digits)__ __ __ __ __ __ __ __ __ __ __ __ Name of Plan _____

In Network Dental Insurance: PRDC is only in-network with Medicaid and Delta Dental Premier plans. We will bill your insurance company for you.

Out of Network Dental Insurance: PRDC accepts out-of-network benefits from any other PPO dental insurance you have. Patients are responsible for the difference between the cost of the procedure and what their insurance pays. We will bill your insurance company for you. Ask one of our staff for assistance in understanding your portion of the bill for any procedure.

Name of Insurance Plan _____ Subscriber Name _____

Employer _____

Subscriber Address, City, State, Zip _____

Subscriber Date of Birth____/____/___Relationship to Patient_____ Subscriber Phone ( ) _____

Insurance Group #_____ Subscriber ID_____ Subscriber SS#_____

How did you hear about PRDC? Did someone refer you to us? Please tell us so we can thank them. _____

Do you use Facebook? YES / NO

Consent for Services and Care: I authorize PRDC to treat the above named patient and disclosed, when requested, any and all information for any illness or injury, medical history consultation, prescription or treatment and copies of all medical records. I assign or authorize direct payment to the designated practice toward any medical procedures performed and authorized PRDC to file Medicaid and Insurance Claims on my behalf. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this authorization shall be considered effective and valid as the original. I understand I am responsible for services not covered by Medicaid/Insurance Plan or if my Medicaid/Insurance Plan is not in effect at the time of service. I understand that PRDC renders services without regard to race, creed, color, or national origin. By my signature I acknowledge that I have been informed of Virginia state law regarding blood testing: In the event that a health care provider or employee is exposed to a patient's bodily fluids in a manner which may transmit disease, the patient will be deemed to have consented to testing for HIV and hepatitis and to release or disclosure of the test results to that health care provider or employee. I consent to all dental treatment deemed necessary by the provider.

Signature of Patient, Parent or Guardian _____ Date _____

Printed Name_____ Relationship _____

Piedmont Regional Dental Clinic Patient Acknowledgments

Patient Name_____ Date of Birth____/____/____

Address _____

Email _____

I am under the age of 18: YES / NO If yes, parent/guardian signature is required.

Organization, if applicable_____

PRDC Insurance and Financial Policy

I acknowledge by signing this section I have read, been informed and understand the following:

- I understand PRDC is in-network with Medicaid and Delta Dental Premier.
- I understand if I have dental insurance other than Medicaid or Delta Dental Premier, I am responsible for all fees/costs not covered by my insurance.
- I understand I will be responsible for any fees insurance does not cover if payment is denied due to ineligibility and/or inactive status.
- I understand I cannot qualify for both PRDC's Affordable Care Program and use my dental insurance benefits. I must choose one billing type.
- I understand after I use the maximum annual allowance of my dental benefits, I can then apply for the Affordable Care Plan.
- I understand I must demonstrate annually that I am income-eligible for the Affordable Care Plan.
- I understand that if I do not pay my bill, PRDC will refer my bill to a collection agency.

Please Initial_____

PRDC Media Release Acknowledgment

I hereby allow the Piedmont Regional Dental Clinic and its agents or assigns, the irrevocable right to use forever any film, video, audio, slides, photographs, digital media, interview material, or combination thereof, for inclusion in any promotional, educational, or advertising purposes, and I am waiving all rights to fees and compensation for any use, replication, publication, and distribution of any such materials.

Please Initial_____

PRDC Acknowledgment of Receipt of Notice of Privacy Practices and Office Policies

I acknowledge by signing this document I have been given a copy, read, been informed, and understand all office policies and the Notice of Privacy Practices. I also acknowledge it is my responsibility, should I have any questions now and/or in the future, to contact PRDC staff for clarification. I further understand that there are instances when PRDC is legally obligated to disclose some or all of my health information.

Please Initial_____

PRDC Weapon-Free Clinic Policy

I agree to abide by PRDC's policy prohibiting weapons inside the Clinic building including both permitted and unpermitted, open carry and concealed weapons of all types.

Please Initial_____

Signature of Patient, Parent or Guardian _____ Date _____

Printed Name _____

Printed Name of Patient Representative_____ Relationship_____

Missed Appointment Policy

In order to keep our fees as low as possible, PRDC must very carefully control costs. When patients fail to show up for their appointments, we still pay our staff even if they don't have a patient to treat, and our other patients who need appointments are unable to receive the care they require if we don't have enough notice to be able to fill the empty appointment slot. Our policies on late arrivals, cancellations and no-shows are based on experience and are a critical part of being able to continue operating our nonprofit dental Clinic.

A missed appointment is defined as (a) an appointment that you do not show up for or (b) an appointment that you provide *less than 24-hour notice to cancel or reschedule.*

Please Confirm Your Appointment: PRDC will contact you multiple times prior to your appointment by text, email and telephone. You must reply to one of these contacts to confirm your appointment. It is as easy as clicking "confirm" and "send." PRDC has voicemail. If it is after normal business hours and you need to cancel, reschedule, or confirm, you may leave a voicemail message at (540) 661-0008.

If you have not confirmed your appointment 48 hours prior to your appointment, PRDC reserves the right to schedule another patient at your appointment time.

Late Arrivals: Please keep in mind that PRDC maintains a very full schedule. Even one patient running late can impact the schedule of the entire Clinic. Please call us and let us know if you are running behind so we can manage accordingly.

If you are more than 15 minutes late for your appointment and we haven't heard from you, PRDC reserves the right to reschedule you.

Cancellations: If you need to cancel or reschedule your appointment, please give PRDC at least a 48-hour notice so we have time to fill the appointment slot with another patient.

If you do not give a 24-hour notice of cancellation, for any reason, it is considered a missed appointment.

Consequences of multiple missed appointments: *Second missed appointment* within six months—$25 missed appointment fee will be assessed on your account ($10 for patients on the Affordable Care Plan) and you cannot reschedule an appointment within the next thirty days.

Third missed appointment within six months—$25 missed appointment fee will be assessed on your account ($10 for patients on the Affordable Care Plan) and you will no longer be able to make advance appointments, although you may still make same-day appointments. Please call us on a day you can come in and we will determine if we can make room for you on our schedule.

I understand Piedmont Regional Dental Clinic's Appointment Policy. I agree to confirm my appointments at least 48 hours in advance, agree to be assessed the missed appointment fees beginning with the second missed appointment in a six-month period, and understand that after missing three appointments in a six-month period I will only be eligible for same-day appointments.

Patient Name: _____

Patient or Guardian Signature: _____

Date: _____

Piedmont Regional Dental Clinic Patient Medical/Dental Health History

Patient Name_____ Date of Birth____/____/____ Age_____

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Who is your primary care physician? (Name, phone number, and city): _____

Are you currently being treated by a specialist? YES / NO If yes, (Name, city, and reason) _____

Have you ever been hospitalized or had a major operation? YES / NO If yes, please explain: _____

Are you taking any medications, pills or drugs? YES / NO Please list all medications you are currently taking:_____

_____

Do you take bisphosphonates (e.g. Fosamax, Reclast, Zometa, Atonel, or Boniva)? YES / NO If yes, which one?_____

Medication Name_____ Dosage_____ Times Per Day _____

Are you allergic to any medications? YES / NO If yes, which ones? _____

Do you have any allergies to things like bee stings or peanuts (other than medications)? YES / NO If yes, please specify:_____

Are you pregnant, trying to become pregnant? YES / NO If yes, estimated due date: _____

Have you given birth within the past year? YES / NO Nursing? YES / NO

Taking oral contraceptives? YES / NO Do you use tobacco? YES / NO

Do you use controlled substances? YES / NO

Do you have, or have you had, any of the following? Please circle.

- ADD/ADHD
- AIDS/HIV Positive
- Alzheimer's
- Anaphylaxis
- Anemia
- Arthritis/Rheumatism
- Artificial Parts/Prosthetic Joints, Pins, Screws in Body
- Asperger's Syndrome
- Asthma
- Asthma/Breathing Problem/ Emphysema
- Autism
- Blood Disease
- Broken Jaw
- Chemical Dependency
- Convulsions/Seizures
- Developmental Delay
- Diabetes
- Diabetes/Hypoglycemia
- Fainting Spells/Dizziness
- Frequent Headaches
- Glaucoma
- Heart Conditions
- Heart Murmur/Mitral Valve Prolapse
- Hemophilia
- Herpes
- High Blood Pressure
- Hives and/or Rash
- Joint Replacement
- Kidney Problems/Dialysis
- Liver Disease (hepatitis, cirrhosis)
- Lung Disease
- Pain in Jaw Joints
- Psychiatric Care
  - Anxiety
  - Depression
  - PTSD
- Radiation Treatment or Chemotherapy
- Recent Weight Loss/Gain
- Rheumatic Fever
- Rheumatic Heart Disease
- Seizures
- Shingles
- Sickle Cell Disease
- Spina Bifida
- Stomach/Intestinal Disease
- Stroke
- Swelling of Limbs
- Take Blood Thinners (i.e. Coumadin, Heparin, Plavix)
- Thyroid Conditions
- Tumors or Growths
- Ulcers
- Venereal Disease

Have you ever had any serious illness not listed above? If yes, please explain: _____

_____

Do you have a "Do Not Resuscitate Order"? YES / NO If yes, PRDC does require a copy to be on file.

Is this your first visit to a dentist? YES / NO

If no, how long has it been since you have visited a dentist?_____years _____months

Who was your previous dentist? _____

Do you like your smile? YES / NO If not, would you like information on how to enhance your smile? YES / NO

What are your current dental concerns?_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health). It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____ Date _____

Provider Signature_____ Date _____

To be completed by PRDC staff: Weight_____Blood Pressure_____

Piedmont Regional Dental Clinic HIPAA Form

Date _____

Patient Name_____ Date of Birth____/____/____

Home Phone ( )_____Cell Phone ( ) _____

Email _____ _____

(inital) PRDC may release my health information to my primary care physician, other licensed medical professionals, and any third party paying for my treatment in order to coordinate care. PRDC also has the right to release information to the following organizations and/or persons regarding your treatment, care, or appointments:

Name_____ Relationship_____ Phone ( )_____

Name_____ Relationship_____ Phone ( )_____

Name_____ Relationship_____ Phone ( )_____

Is it ok to leave messages on your home phone and/or cell phone? YES / NO

HIPAA requirements and the Affordable Care Act allow and sometimes require PRDC to communicate with our patients via email. PRDC uses certified encryption programs to ensure your information remains private and only you, or your authorized representatives, can see it. I understand I may receive appointment reminders and timely reports after dental care.

I understand at times it may be necessary in coordinating care or for insurance purposes for PRDC to share or release my dental health record.

I understand if I wish to have my dental health records transferred to another office or location I will need to sign a Release of Records.

PRDC considers a patient's dental health record to be the following information:

Clinical Notes	Patient Registration	Medication History
Radiographs	Treatment Plan	HIPAA Form
Account Ledger	Medical History Intake	PRDC Patient Acknowledgment Form

In case my dental health records need to be released: I authorize PRDC to do so via (please circle all that apply): FAX / PHONE / EMAIL

I understand that release of any information, other than in person, can result in accidental release to someone other than myself; however, PRDC makes all reasonable efforts to maintain patient's privacy. I understand by agreeing to release of this information using phone, fax, or email that there is a possibility that this information could be given to someone other than myself. It is my responsibility to arrange with my physician for consultation and interpretation of the healthcare information. I understand this acknowledgment is updated as needed or by request of myself. I understand that if I would like to revoke any information on this form I must do so in writing.

Signature of Patient, Parent or Guardian _____ Date _____

Printed Name_____ Relationship _____

Piedmont Regional Dental Clinic Patient Rights and Responsibilities

1. As a PRDC patient, you have rights. You have the right to:
   - Receive considerate and respectful care regardless of your race, gender, national origin, religion or economic status.
   - Understand your diagnosis, treatment options.
   - Know how much the services you request will cost.
   - Know the name and credentials of the providers caring for you
   - Demand privacy for your personal and medical records.
   - Receive quality dental care which takes into consideration your psychological, spiritual, and cultural values as well as your economic situation.
   - Express grievances in an appropriate manner and have them addressed directly.

   As a PRDC patient, you also have responsibilities. You are responsible for:
   - Providing accurate and complete contact information and medical history.
   - Asking questions if you do not understand a diagnosis, a cost, or treatment options.
   - Promptly paying for your services.
   - Bringing an interpreter such as a friend or family member (18 or older) with you to your appointment if you cannot communicate in English.
   - Being respectful to our dentists, staff and other patients.
   - Refraining from using a cell phone/cameras in the treatment areas out of respect for the privacy of other patients as well as the noise factor.
   - Arriving on-time for your appointments.
   - Providing 24 hours notice if you must cancel an appointment.
   - Accepting the repercussions of any no shows. For more information, see # 3.

2. **Financial Policy:** PRDC accepts patients of all economic levels. Patients at or below 200% of the Federal Poverty Level qualify for our Affordable Care Plan and receive significant discounts to prevailing commercial rates. Having insurance coverage does not disqualify you from our Affordable Care Plan.

   PRDC will help you determine the lowest possible fee for your services based on the treatment options you select, your insurance benefits (if any) and your household income. PRDC is happy to submit your insurance claims for you.

   All patients not covered by Medicaid or Delta Dental Premier must pre-pay for their services by cash, credit card, Health Savings Account or Care Credit. One exception are recurring hygiene appointments which only require a $20 deposit.

   Should you pre-pay for a procedure you later do not wish to receive, PRDC will refund your money within 30 days of receiving a written refund request.

3. **Missed Appointment Policy:** PRDC is a small, non-profit dental safety net clinic. In order to keep our fees as low as possible, every hour we pay our staff must be productive (i.e. caring for a patient). When patients fail to show up for their appointments, we must still pay our staff and it causes significant hardship for the Clinic. Other patients who need the appointment spot are also delayed in receiving the care they require. We thank you for understanding that our policies on late arrivals, cancellations and no-shows are based on experience and are important to our ability to continue operating the Clinic.

   PRDC enforces a very strict missed appointment policy. A missed appointment is defined as (a) an appointment that you do not show up for and/or (b) an appointment that you provide less than 24-hour notice to cancel or reschedule. PRDC requests you make all possible attempts to keep your scheduled appointment and respect our staff and the other patients who are on time. As a courtesy to our patients, we will confirm your appointment 48 hours prior to your scheduled appointment. We do request a call or text back to confirm your appointment. If we do not receive your appointment confirmation by 12:00 pm the day prior to your appointment, we have the right to reschedule your appointment.

   Late Arrivals: Please keep in mind PRDC maintains a very full schedule. Even one patient running late can impact the schedule of the entire Clinic. If you are late for your appointment, PRDC reserves the right to reschedule you. We ask you to arrive 10 minutes before your appointment to allow time for registration.

   Cancellations: If you need to cancel or reschedule your appointment, please give PRDC at least a 24-hour notice. This notification allows PRDC the opportunity to offer services to another patient who might be in emergent need. If you do not give a 24-hour notice, or cancel the same day as your appointment for any reason, it is considered a missed appointment.

   Please note: PRDC has voicemail. If it is after normal business hours and you need to cancel, reschedule, or confirm, you may leave a voicemail message at (540) 661-0008.

   Repercussions of missed appointments:
   - 2nd missed appointment—30 day wait for your next appointment
   - 3rd missed appointment—PRDC will no longer schedule you for future appointments. Please call us on a day you know you can come in, and we will work you into the schedule if space is available.

4. **Preventative Care:** We encourage all patients to follow through with their suggested treatment plan. PRDC requires all patients to have a six-month periodic exam regardless of the status of their treatment plan. If you have not completed your treatment within six months of your last exam, you will be required to have a periodic exam before further treatment will be completed. This is a quality of care standard for PRDC and our patients. There will be no exceptions to this policy.

   A periodic exam typically includes a cleaning. If you have very few teeth your exam may cost less depending upon the condition of those teeth.

5. **Concerns or Suggestions:** We expect for each patient to be treated with dignity, respect, and the highest level of quality dentistry. With that in mind, we expect our patients to treat our employees with respect and courtesy, as well. If you have any concerns, please let us know. We always welcome and encourage suggestions to better serve you. You may direct any concerns or suggestions to the Executive Director.

6. **Snow Dates:** PRDC will update its phone message, send emails, post to Facebook and the website if we are closed or opening late due to snow.

KEEP FOR YOUR RECORDS

Piedmont Regional Dental Clinic Notice of Privacy Policies

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

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 5-1-2011, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosure of Health Information

We use and disclose health information about you without authorization for the following purpose:

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You or Your Personal Representative: We must disclose your health information to you, as described in the Patients Rights section of this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inference of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk for contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $_____ for each page, $_____ per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional request.

KEEP FOR YOUR RECORDS

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or healthcare operations (as defined by HIPAA) if the protected health information pertains solely to a healthcare item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make a request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronics Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Questions or Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Mary Foley Hintermann, Executive Director **Telephone:** 540-661-0008 **Fax:** 540-661-1070

Email: mary.hintermann@vaprdc.org **Address:** 13296 James Madison Hwy., Orange, Va. 22960

KEEP FOR YOUR RECORDS