Smiles for the Future Pediatric Dentistry & Orthodontics

ADULT REGISTRATION FORM

Today's Date:_____

PATIENT'S NAME: _____**MIDDLE:** _____**M/F**_____ **DOB:**_____
FIRST AND LAST

ADDRESS: _____
STREET TOWN ZIP CODE

HOME# (____) _____ **WORK # (___)** _____**CELL# (___)**_____

MARRIED DIVORCED SINGLE SEPARATED DOMESTIC PARTNERSHIP (PLEASE CIRCLE)

EMPLOYER: _____ **OCCUPATION:** _____

EMERGENCY CONTACT (NOT LIVING WITH YOU) _____ **(____)** _____ _____
NAME PHONE RELATIONSHIP

HOW DID YOU HEAR ABOUT US? _____

PLEASE COMPLETE:

☐ NO DENTAL INSURANCE (**PAYMENT IS EXPECTED AT TIME OF SERVICE)**

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE (copy of card required to bill services)

Insured's Name: _____

Relationship to Patient: _____

Insurance Carrier: _____ _____

ID# _____ **Group#**_____

Carrier Ph#_____

Policy Effective Date:_____

ADDITIONAL INSURANCE (copy of card required to bill services)

Insured's Name:_____

Relationship to Patient _____

Insurance Carrier:_____

ID#:_____**Group #**_____

Carrier Ph#:_____

Policy Effective Date:_____

(Complete only if insured is different from the patient)

Employer:_____

Occupation:_____

DOB: _____

SS#:_____

Home#:_____**Work #**_____

Cell#_____

Employer:_____

Occupation:_____

DOB:_____

SS#:_____

Home#:_____**Work#**_____

Cell#_____

I hereby authorize Smiles for the Future Pediatric Dentistry and Orthodontics to submit a claim in an effort to obtain payment from my insurance carrier(s) for services rendered. I understand that the financial responsibility remains with me regardless of coverage.

Signature:_____

Smiles for the Future Pediatric Dentistry & Orthodontics

ADULT HEALTH & SOCIAL HISTORY

Patient Name: _____ **Middle:** _____ **Date of Birth:** _____

1. Do you have any health problems (past or present)? □ Yes □ No
   If yes, explain _____
2. Are you currently seeing a physician for any problem? □ Yes □ No
   If yes, explain _____
3. Do you take any medications? □ Yes □ No
   If yes, list (including dose)_____
4. Do you have an allergy to any food, medicine or materials (e.g. antibiotics, latex)? □ Yes □ No
   If yes, explain _____
5. Have you ever had a heart murmur, heart defect or rheumatic fever? □ Yes □ No
   If yes, explain _____
6. Have you ever been injured, hospitalized or received surgery? □ Yes □ No
   If yes, explain _____
7. Are you pregnant or have been pregnant in the past? □ Yes □ No
8. Have you ever had a blood transfusion? □ Yes □ No
9. Have you ever had any of the following:
   - Breathing problems or asthma? □ Yes □ No
   - Airway, tonsil or adenoid problems? □ Yes □ No
   - Blood problems such as sickle cell anemia? □ Yes □ No
   - Easy bleeding or bruising? □ Yes □ No
   - Seizures, dizziness, fainting spells or epilepsy? □ Yes □ No
   - Frequent headaches? □ Yes □ No
   - Frequent cough or tuberculosis (T.B.)? □ Yes □ No
   - Hepatitis or liver problems? □ Yes □ No
   - Stomach, bowel problems or gastric reflux? □ Yes □ No
   - Diabetes, excessive thirst or urination? □ Yes □ No
   - Or other endocrine or hormone problems? □ Yes □ No
   - Kidney problems? □ Yes □ No
   - Hives or skin rash? □ Yes □ No
   - AIDS or HIV infection? □ Yes □ No
   - General anesthesia? □ Yes □ No
   - Birth defect or disability? □ Yes □ No

10. Does anyone in the immediate family have a history of allergies, diabetes, etc.? □ Yes □ No
    If yes, explain _____
11. Did you have any health problems or illnesses when younger or at birth? □ Yes □ No
    If yes, explain _____
12. Do you have or had any disease, condition or problem not listed above? □ Yes □ No
    If yes, explain _____
13. Previous DENTIST's name and address, If applicable: _____

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

_____ _____

Signature of Patient Date

Smiles for the Future Pediatric Dentistry & Orthodontics

FINANCIAL POLICY & DENTAL INSURANCE COVERAGE PRACTICE POLICIES

We participate with some dental plans and we will submit our claims to most insurance companies for you, however **NOT ALL SERVICES MAY BE COVERED BY INSURANCE PLANS**.

- If you do not have any dental insurance coverage, ***payment is expected at the time of service.***
- If you or your child is in need of extensive dental work, we can submit a "pre-determination of benefits" to your insurance company so you will have an insurance **ESTIMATE** of the amount you will be responsible to pay.
- Financial arrangements may be made upon request. However, they must be made prior to the first restorative or orthodontic appointment.
- I understand that I will be responsible to pay, at the time of service, any and all amounts not paid or covered by my dental insurance.
- I realize that such charges will include but may not be limited to amounts incurred from deductibles, co-payments, and amounts not paid by my dental insurance due to yearly/lifetime maximums of my benefits.
- I understand and agree that Smiles for the Future Pediatric Dentistry & Orthodontics does not represent my dental insurance company and that Smiles for the Future Pediatric Dentistry & Orthodontics cannot make ANY representation or warranty that my dental insurance company will cover all or any portion of the dental services provided by Smiles for the Future Pediatric Dentistry & Orthodontics.
- I acknowledge that it is my ultimate and sole responsibility to determine whether a dental service, procedure, or treatment program is covered by my dental insurance, and if covered, the amount of coverage that will be provided and whether my benefits are exhausted or will be exhausted during the service, procedure, or treatment program.
- I also acknowledge and understand that Smiles for the Future Pediatric Dentistry & Orthodontics will not, as a matter of policy, agree to halt any service, procedure, or treatment program solely because my dental insurance benefits have become exhausted.
- I understand that Smiles for the Future Pediatric Dentistry & Orthodontics cannot know at what point in my procedure or treatment my insurance benefits will exhaust.
- A late payment charge of 1½% per month (18% annually) will be applied to all accounts that are unpaid over 60 days. You will be responsible for all collection costs, reasonable attorney fees, and court costs. There is a $30 returned check fee each time an unpaid check is returned to us.
- I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Smiles for the Future Pediatric Dentistry & Orthodontics and I agree to be responsible for all charges for dental services and materials, not paid by my dental benefit plan.
- I confirm that any statement made by any one at Smiles for the Future Pediatric Dentistry & Orthodontics concerning my dental insurance coverage cannot be relied upon as a guarantee of coverage.

I confirm that no representation has been made to me by any one at Smiles for the Future Pediatric Dentistry & Orthodontics that is contrary in any way to the above notice and disclaimer.

Patient's Name: _____

Parent or legal guardian (print) _____

Parent or legal guardian (signature) _____

Smiles for the Future Pediatric Dentistry &Orthodontics

Authorization for Use and Disclosure of Protected Health Information

Patient's Full Name:_____ Date of Birth ____/____/____

I hereby authorize: Smiles for the Future Pediatric Dentistry and Orthodontics to use and/or disclose the Protected Health Information described below to:

_____

Parent(s) or Legal Guardian(s) for the purposes(s) of billing information.

Protected Health Information: Any and all ***OR*** Specific information to be released is indicated below

- _____
- _____
- _____

Communication: We offer Complementary automated Appointment Reminders. Please choose an option below**. There is a $40 fee applied for missed appointments if a 24 hour notice is not provided.** This service does not exempt the fee in the event you do not receive a reminder. There is not a phone call option with this service.

Email:_____

Text:_____

Home:_____Work:_____Cell:_____

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.

2. I understand that Smiles for the Future will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

3. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Office of Smiles for the Future. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.

4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

COPY PROVIDED: Smiles for the Future shall supply a copy of this signed authorization to you upon your request. This information will be disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

Connecticut state law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions. By my signature below, I authorize release of the following medical information that may be held by Smiles for the Future: information pertaining to my HIV status, records of mental health care and treatment, records of abuse, records of care and treatment for sexually transmitted disease, and records of substance abuse care and treatment.

____/____/____ _____ _____

Date Signature of individual patient or representative Authority or relationship of representative

Smiles for the Future, Pediatric Dentistry & Orthodontics

Cancellation and No Show Appointment Policy

To all of our patients:

Smiles for the Future Pediatric Dentistry & Orthodontics is dedicated to providing your children with the best dental care. Please understand that a last minute cancellation or "no show" does not allow us enough time to accommodate another patient. Because the time we allot for you is valuable, we ask that you **please provide our office at least 24hours notice, if you must cancel or reschedule an appointment.**

Please note, there is a **$40.00 non-refundable charge** for any appointment that is cancelled, rescheduled or "no showed" within 24 hours of your scheduled time. After three "no shows" we reserve the right to discharge a patient from our practice.

We do offer an automated **complimentary reminder** text or e-mail of scheduled appointments but request that you keep a primary reminder to ensure that the visit is attended. This automated service **does not provide a PHONE CALL OPTION**. If text and e-mail are not available to you, you will not be able to participate with this automated complimentary service.

* ***Missed appointments due to not receiving a complimentary reminder are still subject to the non-refundable charge.***

Thank you for understanding. We look forward to providing dental care to you or your child (ren)

Parent/Guardian (please print)_____

Parent/Guardian (signature)_____

Child:_____

NOTICE OF PRIVACY PRACTICES
SMILES FOR THE FUTURE PEDIATRIC DENTISTRY & ORTHODONTICS, LLC

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

We here at Smiles for the Future remain committed to protecting our patient's personal dental/health information and encourage you to contact our office with any questions or concerns regarding these safeguards.

Effective Date: January 1, 2011
This Notice was revised on November 25, 2013.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer: Amy Russell, CMPE
Mailing Address: 49 Welles Street Suite 211 Glastonbury CT 06033
Telephone: 860-633-5246
Fax: 860-633-5248
Email: info@smilesforthefuture.com

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another dental/health care provider, dental/health plan, your employer, or a dental/health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of dental/health care to you, or (3) the past, present, or future payment for your dental/health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you dental treatment or services and to manage and coordinate your dental care. For example, your Protected Health Information may be provided to a physician, dentist or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician, dentist or other health care provider has the necessary information to

diagnose or treat you or provide you with a service.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a dental/health plan, or a third party. This use and disclosure may include certain activities that your dental/health insurance plan may undertake before it approves or pays for the dental/health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your dental/health plan information about your treatment in order for your dental/health plan to agree to pay for that treatment.

- **For Dental Care Operations.** We may use and disclose Protected Health Information for our dental care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to dentists, physicians, nurses, dental technicians, dental students, and other authorized personnel for educational and learning purposes.

- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for dental care, or to contact you to tell you about possible treatment options or alternatives or dental related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

- **Military and Veterans.** If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the dental/health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your dental/health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information

requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with dental/health care; (2) to protect your dental/health and safety or the dental/health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your dental/health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

- **Fundraising Activities.** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures of Protected Health Information for marketing purposes; and
3. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed dental/healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

- **Right to an Electronic Copy of Electronic Dental Records (currently we are not using a electronic dental record only paper charts).** If your Protected Health Information is maintained in an electronic format (known as an electronic dental record) , you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or dental/healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic dental records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or dental/health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a dental/health plan for payment or dental/health care operation purposes and such information you wish to restrict pertains solely to a dental/health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your dental/health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a dental/health plan for purposes of payment or dental/health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your

work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.