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HIPPA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

Use and Disclosures of Protected Health Information
Your Protected Health Information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment
We will use and disclose our Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your Protected Health Information as necessary to a home health agency that provides care to you. For example, your Protected Health Information may be provided to a physician or specialist to whom you have been referred to ensure that the physician/specialist has the necessary information to diagnose or treat you.

Payment
Your Protected Health Information will be used, as needed, to obtain payment for your dental services. For example, obtaining approval for major dental work may require that your relevant protected health information be disclosed to the health plan to obtain approval for the treatment to be covered by your insurance plan.

Healthcare Operations
We may use or disclose, as needed, your Protected Health Information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities; training of students; licensing; and conducting or arranging for other business activities. For example, we may disclose your Protected Health Information to dental school students or temporary staff who sees patients at our office. In addition, we may use a sign – in sheet at the registration desk where you will be asked to sign your name and indicate the purpose of your visit. We may also call you by name in the waiting room when your dentist/hygienist is ready to see you. We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment by mail and by telephone.

We may disclose your Protected Health Information in the following situations without authorization. These situations include: Public Health issues, i.e. Communicable Diseases; Health Oversight; Abuse or Neglect; Good and Drug Administration requirements; Legal Activity; Military Activity and National Security; Worker's Compensation; Inmates; Required Uses of the Dept of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your dentist or dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your Protected Health Information. Under federal law, however, yo7 may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and Protected Health Information that is subject to law that prohibits access to Protected Health Information.

You have the right to request a restriction of your Protected Health Information. This means you may ask us not to use or disclose any part of your Protected Health Information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your Protected Health Information not be disclosed to family members or friends who may be involved in your care or notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your Protected Health Information, your Protected Health Information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your Protected Health Information. If we deny your request for 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your Protected Health Information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003**.

How would you prefer to be contacted? (Please check all that apply) At home ___ at work ___ by cell phone ___
May we leave a message on your answering machine? Yes ___ No ___ Voice mail? Yes ___ No ___

Please list designated relatives and/or friends we may contact if we cannot reach you:

Name: _____ Phone #: _____
Name: _____ Phone #: _____
Name: _____ Phone #: _____
Name: _____ Phone #: _____

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this form, please as to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practices.

Signature _____ Print name: _____ Date: _____