HIPAA Notice of Privacy Practices and Office Policy

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 that related to your past, present or future physical or mental health or condition and related health care services, including information related to sexually transmitted diseases and HIV.

Uses 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 your 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 and 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, specialist or dentist to whom you have been referred to ensure that the above named has the necessary information to diagnose or treat you.

Office Policy: I authorize DeMarco Family Dental referred to as "practice" hereafter, to take necessary radiographs, study models, photos and other diagnostic aids as needed to make a thorough diagnosis. I authorize photos and radiographs to be mailed/emailed to referring physicians and insurance companies. I authorize this practice to perform all recommended treatment and agreed upon treatment. I also authorize the use of anesthesia, and other medications (as needed) and am fully aware that using anesthetic agents involve certain risks.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. **Broken Appointment Fees will be charged to my account for all missed appointments without 48 hours' notice:**

- **$75.00 for all treatment appointments**
- **$25.00 for all wellness appointments**

Financial: I am responsible for payment of all services rendered on my behalf and dependents. I have been informed that payment is due at the time of service. I am aware that 1% interest will be applied to accounts over 30 days. Should my account become delinquent, I will assume all additional collections costs and fees. Please understand that payment of your bill is part of your treatment. We accept most major credit cards, cash and checks. We offer an extended payment plan through care credit with interest free financing upon credit approval. Our office policy for any major work (crowns, dentures, partials, bridges, etc.) requires ½ deposit when scheduling and remainder after completion. Insurance will be calculated into your total estimated treatment 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 dental students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your

protected health information in the following situation without your authorization. These situation include: as Required By Law: Public health issues are required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration Requirement; Legal Proceeding; Law Enforcement; Coroner, Funeral Directors and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement 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 the dentist's practice has taken an action in reliance in the use or disclosure indicated in the authorization. I authorize this practice to release to staff, hospitals, healthcare service plans and insurance companies. **Your insurance is a contract between YOU and YOUR INSURANCE COMPANY. We are not a third party to that contract. IT IS YOUR RESPONSIBILITY TO KEEP TRACK OF YOUR DENTAL BENEFITS THROUGHOUT THE YEAR.**

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, you may not inspect or copy information for the purposes of, or in 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 purposes 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 for notification purposes as described in the 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 your 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 account 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 your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against your for filing a complaint. 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 ask to speak with our HIPAA Compliance Officer/Manager in person or by phone at **609-296-8700.**

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Patient/Guardian Signature_____ **Date**_____