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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential. This federal law gives you, the patient significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operation.

1. Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.
2. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. For example, we disclose treatment information when billing a dental plan for you dental services.
3. Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards, in electronic or paper form &/or leaving voice messages at home &/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorizations.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
3. The rights to access inspect and copy your protected health information.
4. The right to request an amendment to you protected health information.
5. The right to receive an accounting of disclosures of protected health information outside of treatment, payment & health care operations.
6. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 31, 2012 and we are required to abide by the terms of the *Notice of Privacy Practices* currently in effect. We reserve the right to change the terms of our *Notice of Privacy Practices* and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our *Notice of Privacy Practices* will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

At times we will need to contact you concerning information that is specific to you, your treatment & your dental needs. Information that is requested to be sent to you, or on your behalf, by our office via email will be sent in standard email format. We do not have encrypted services available for such communication. We may have the need to use the telephone, emails &/or postcards for confirmation of appointments or verification of health/dental needs. We will remain mindful all HIPAA laws concerning release of information in these instances.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Office Name: Springfield Family Dental
Address: 636 W. Republic Rd. Suite 120
City, State, Zip: Springfield, MO 65807
Phone: 417-882-3200

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll free)

ACKNOWLEDGE OF PRIVACY PRACTICES-HIPAA

The Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide & coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers for my health services. Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices contain a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

At times we will need to contact you concerning information that is specific to you, your treatment & your dental needs. Information that is requested to be sent to you, or on your behalf, by our office via email will be sent in standard email format. We do not have encrypted services available for such communication. We may have the need to use the telephone, emails &/or postcards for confirmation of appointments or verification of health/dental needs. We will remain mindful all HIPAA laws concerning release of information in these instances.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

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Patient's Printed Name

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Patient/Guardian's Signature Date

Please list below anyone who the patient allows to receive about their dental needs.

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