Notice of Privacy Practices

Dear Patient:
It is our desire to communicate to you that we are taking the new Federal (HIPPA—Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not want you to delay treatment because you are afraid your personal health history might be made available to others outside of our office. We will use and communicate your HEALTH HISTORY only for the purpose of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist and business office staff. We may share your health information with physicians, referring dentists, dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Our best teaching opportunities use clinical situations experienced by patients receiving care at our office. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processed of certification, licensing or credentialing activities.

In Patient Reminders

We believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. We may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you. Communication with our patients to ensure they receive the best preventive and restorative care is very important to us. The communication methods we may use include the following: postcards, letters and telephone reminders (unless you tell us you do not want these reminders).

Abuse or Neglect

We may notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstance, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patients Rights

You have the right to request restrictions on certain uses and disclosures of your health information.
You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed.
You have the right to read, review and copy your health information including your complete chart, x-rays, and billing records. A reasonable fee will apply to duplicate and assemble your copy.
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.
You have the right to ask us for a description of how and where your health information was used by our office for any reason other than treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward.
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We do reserve the right to change the terms of our notice.
You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Patient Acknowledgment
Patient Name(s):

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Thank you very much for taking time to review how we are carefully using your health information.

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Patient Signature
Date_____/_____/_____