NOTICE OF PRIVACY PRACTICES

(DENTAL)

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") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act 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.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

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 authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- 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.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

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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 _____, 20___ 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. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

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
(202) 619-0257
Toll Free: 1-877-696-6775

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Comfort Family Dental, LLC
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23 White St.
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732-747-7730

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

Patient Name_____
Patient Date of Birth _____
Patient E-Mail_____
Patient Phone Number_____

By signing this form, you acknowledge that Comfort Family Dental, LLC has provided you access to a copy of its HIPAA Privacy Notice, which explains how your health information will be handled in various situations. By law, we are required to have you sign this form on your first date of service with us.

Please specify by checking the appropriate answer below if we may leave health-related information (e.g., lab/radiology/biopsy results, billing issues or other doctor-patient communications) with/on:

Home Answering Machine _____Yes _____No
Work Voicemail _____Yes _____No
Personal/Work Email _____Yes _____No
Provide Email Address: _____
Cell Phone _____Yes _____No
Relative or Other Person Living With You _____Yes _____No

Please note that if the above section is not completed, we will assume that we have your approval to contact you using any one of these methods.

[ ] The Practice has provided me with a copy of its Privacy Notice. I acknowledge that I have read, understand and agree to the above.

[ ] I have read the Privacy Notice and DO NOT AGREE to its provisions.

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Comfort Family Dental making the limited disclosures described above. (I understand that I am not required to list anyone. I also understand that I may change this list at anytime in writing.)
Print Name: _____ Relationship _____
Print Name: _____ Relationship _____
Print Name: _____ Relationship _____

_____ _____
Patient's/Guardian Signature Date