Children's DENTAL CENTRE

Kaitlin J Hoogeveen, DDS
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childrensdentalcentresc.com

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.

Under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), all medical records and other individually identifiable protected health information (PHI) of which we have knowledge must be kept confidential. All PHI used by us or disclosed by us is covered by this Act regardless of whether this PHI is in electronic, oral or paper form. Several new rights are granted to patients under this Act allowing control over how your PHI is used, how you can access it, and in some cases amend it.

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

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPPA.

This Notice of Privacy is effective on October 1, 2017.

We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

Should any breach of unsecured PHI ever occur, we will notify the patient(s) involved within 10 business days of discovery of this breach.

You will be asked to sign a consent form authorizing us to use and disclose your personal health information only for the following purposes, as defined under the Act:

- Treatment means the provision, coordination, or management of health care and related services by one or more healthcare providers, including the coordination of management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or referral of a patient for health care from one healthcare provider to another. An example of this would be a dentist referral to an orthodontist.
- Payment means obtaining reimbursement for the provision of health care; determination of eligibility of coverage; billing; claims management; collection activities; justification of charges; and disclosure to consumer reporting agencies; protected health information relating to the collection of reimbursements (only certain information may be disclosed). An example of this would be submitting your bill for health care services to your insurance company.
- Health care operations or any activity related to covered functions in which we participate in the function of our offices, such as conducting quality assessment activities; protocol development; case management and care coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; fundraising; and marketing for which an authorization is not required. An example of this would be evaluation of customer service given to patients.

We may, without prior consent use or disclose your PHI to carry out treatment, payment or health care operations:

- Directly to you at your request;
- In an emergency treatment situation, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment; if we are required by law to treat you and attempts to obtain consent are unsuccessful; or if we attempt to obtain consent but are unable, due to the barriers of communication, but we determine in our professional opinion that treatment is clearly inferred from the circumstances;
- Pursuant to and in compliance with an authorization signed by you; and
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree to or prohibit or restrict the use or disclosure. This may be an oral agreement between us and may include a directory maintained at our facility containing specific information allowed by the Act.

We may de-identify your personal health information by using codes or removing all individually identifiable health information.

All other uses and disclosures will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice, and we will abide by that request.

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However, exception would be any actions already taken, relying on your authorization, and prior to revocation notice.

If you have paid for services out of pocket, in full, and request that we not disclose PHI related solely to these services to a health plan, we will abide by this request except where required by law to make a disclosure.

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

A written authorization from you will be required to release the following information:

- Use and disclosure of psychotherapy notes
- Use and disclosure of PHI for marketing purposes
- Disclosures that constitute the sale of PHI
- Other uses and disclosures of PHI not described in this Notice of Privacy Practices

Under HIPPA, you have the following rights with respect to your protected health information:

- No use or disclosure of genetic information will be released for underwriting purposes.
- You have the right to request restrictions on certain uses and disclosures of protected health information, including restrictions placed upon disclosure to family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a requested restriction;
- You have the right to receive confidential communications of your protected health information, either directly from us or from us by alternative means or from alternative locations;
- You have the right to inspect and copy your protected health information; you may also request your PHI in an electronic format if we use an electronic (paperless) recordkeeping system.
- You have the right to amend PHI, however, this request may be denied under certain circumstances;
- You have the right to receive an accounting of disclosures of your protected health information made by us in the six years prior to the date of the account request; and
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically.

If you feel your privacy rights or the provisions of this notice of privacy policies has been violated, you have the right to file a formal written complaint.

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

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I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient's Name:_____**DOB:**_____/_____/_____

Patient's Name:_____**DOB:**_____/_____/_____

Patient's Name:_____**DOB:**_____/_____/_____

Patient's Name:_____**DOB:**_____/_____/_____

Patient's Name:_____**DOB:**_____/_____/_____

_____ _____

Signature of Parent/Legal Guardian **Date**