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.

ITEM 070-6028/25944 © MAY 2002

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

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

LAKE COUNTRY DENTAL & ASSOCIATES
8461 Boat Club Road
Fort Worth, TX 76179

I,_____, hereby acknowledge that I have received and/or reviewed a
(Print Patient Name)
copy of **Lake Country Dental & Associates'** *HIPAA Notice of Privacy Practices*.

I understand that **Lake Country Dental & Associates** *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of **Lake Country Dental & Associates'** revised *HIPAA Notice of Privacy Practices* upon request. I understand that, if I have questions about **Lake Country Dental & Associates'** *HIPAA Notice of Privacy Practices*, I may contact:

Lake Country Dental & Associates
Ray D. Snider, DDS
8461 Boat Club Road
Fort Worth, TX 76179
817.236.8771

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that **Lake Country Dental & Associates** will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **Lake Country Dental & Associates'** privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Ray D. Snider, DDS noted above, for assistance.

_____ _____
Patient Signature Date

_____ _____
Signature of Parent/Guardian Print Name of Parent/Guardian

FOR OFFICE USE ONLY

Lake Country Dental & Associates made a good-faith effort to obtain Acknowledgement from the patient noted above, receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, **Lake Country Dental & Associates** was unable to obtain a signed Acknowledgement for the following reasons(s):

□ Refusal to sign Acknowledgement on _____ (date)

□ Communication barriers prohibited us from obtaining a signed Acknowledgement

□ An emergency situation prohibited us from obtaining a signed Acknowledgement

□ Other (describe): _____