Leon Springs Family Dental
<u>Notice of Privacy Protection Act</u>

As a provider of medical services we are required by law, under the Health Insurance Portability and Accountability Act (HIPAA), to inform you of your rights to protect your personal health information, effective April 14, 2003.

OUR DUTY TO YOU
As your dental provider we are doing everything within our control to maintain your records and information in a secure and private manner. We do reserve the right to change our policies with proper notice to you in advance. We will only release information about you and your treatment under specific circumstances, which include the follow:

Treatment: We may use you information during the course of treatment. This includes releasing information to other dentists, physicians, and other health care providers when treatment dictates such as necessary. Also know that our staff will have access to your information as extensions of our function here as health care providers.

Payment: We may disclose personal information about you and your treatment to third party carriers and payment processing entities. This includes insurance carriers, claims clearinghouses, collection agencies, and third party administrators such as employee medical reimbursement accounts.

Operations: We may use your information in the course of everyday operations of our office. This may include but is not limited to quality assurance/quality improvement reviews, credentialing, training, and clarification and accreditation activities.

Miscellaneous Uses: At certain times we may be required to use your information for purposes other than as described above. Examples of these uses include: appointment reminders (cards, voice messages, and letters), abuse/neglect, national security, family and friends (only to the extent for use in healthcare operations or payment).

YOUR RIGHTS
Restrictions: You have the right to request restrictions or disclosure usage. We are not required to accept these restrictions but we will make a note of the request and honor the request if reasonably applicable.

Access: You have the right to access your personal health information. A request for access must be made in writing. You may speak to our privacy officer to schedule an appointment to view your information. You may also request a copy of your personal health information. We will charge you a fee for the copies as set by the Texas State Board of Dental Examiners.

Amendment: You have the right to request that we amend your personal information. Your request must be in writing and explain what should be amended and rationale for such request.

Disclosures: You have the right to request a list of any unusual disclosures of your personal health information that fall outside the normal instances required to carry out treatment, payment or regular operations. We reserve the right to charge for the reproduction of documentation if requested more than once in a 12-month period.

Complaints: Please contact our privacy officer for any questions or complaints. If you feel that we have violated your privacy you may submit a written complaint to the US Department of Health and Human Services. We can provide you with the address upon request.

Acknowledgement of Receipt of
Notice of Privacy Practices

By signing below I acknowledge that I have received and reviewed the Notice of Privacy Protection. I agree with the terms of this notice and understand my rights under this notice as written.

By signing below I consent for the use of my personal health information by Leon Springs Family Dental for treatment, payment, and operations and other uses as described in the privacy notice.

I also understand that I have the right not to sign this agreement.

____
Patient Name (Print)

____
Patient/Guardian Signature

____
Relationship to Patient

____
Date

If we are unable to get your acknowledgement then our office will make a notation as to the reason why it was not obtained.

Reason why acknowledgement was not obtained:

____

____

____

____
Patient Name (Print)

____
Patient/Guardian Signature

____
Staff Member

____
Date