HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control you protected health information, that may identify you and relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay for your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. This includes the coordination or management of your dental care with a third party. For example, your protected health information may be provided to a specialist to whom you have been referred to ensure that the specialist has the necessary information to diagnose or treat you.

Payment
You protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a restoration may require that your relevant protected health information be disclosed to the dental plan to obtain approval for the restoration.

Healthcare Operations
We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to , quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without authorization. These situations include: as Required by Law, Public Health issues are required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors: and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Use and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 **Other Permitted and Required Uses and Disclosures** Will be made only with your consent authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your dentist's practice has taken an action in reliance on the use or disclosure indicated in this authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Health Professional.

You have the right to request to receive confidential communications from us by alternate means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. Electronically.

You have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a state of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice

Complaints
You may address concerns to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

T**his notice was published and becomes effective on or before November 19,2013**
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (616)988-9485.

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accounting Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly which may include email correspondence
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Initial/Relationship to Patient _____

If there is anyone that you would allow us to discuss treatment, appointments and account information, please write their name on the line(s) below.

_____ Name/Relationship to Patient

_____ Name/Relationship to Patient

_____ Name/Relationship to Patient

_____ Name/Relationship to Patient

Media Release

I hereby consent for Growing Smiles Pediatric Dentistry, P.C. to use, reproduce, exhibit or distribute (in full or in part) any photograph, video, film, and/or audio recordings made of my child or his/her likeness; and/or any written extract of such recordings in which he/she may be included, for any purpose whatsoever, in any medium now known or in the future invented.

I hereby release, discharge, and agree to hold harmless Growing Smiles Pediatric Dentistry, P.C. and all persons acting under its permission or authority from any liability or injury that may occur while performing or appearing in the said video, audio, or photographic production.

_____

Initial

Cancellation Agreement

Our dental practice takes pride in providing quality care for our patients and the combination of communication and cooperation are key elements for a successful office. Because we value our patients' time, we emphasize the importance of keeping scheduled appointments. If an appointment cannot be kept, we ask our patients to give us 48 hours or 2 business days advance notice. This gives our team the appropriate time to contact other patients who are in need of dental care. IF YOU NO CALL NO SHOW YOUR VISIT or CANCEL SHORT NOTICE, WE WILL ASSESS A $40.00 MISSED APPOINTMENT FEE TO YOUR ACCOUNT.

We do understand that there are emergencies and a 48 hour advance notice may not be possible at all times. We ask that you contact our office as soon as possible to reschedule your appointment. If there is a history of failed appointments, we may impose a pre-payment policy, charge a missed appointment fee or you may not be re-appointed.

Parent or Legal Guardian: _____
(Print name)

Signature: _____Date:_____

Address: _____

City: _____ State: _____ Zip: _____

growing smiles pediatric dentistry