Dental Health Associates
Swanton

210 W. Airport Hwy., P.O. Box 270 Swanton, Ohio 43558
Phone: 419.826.2525 Fax 419.825.5067
swanton.office@dentalha.com dhaswanton.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.

The Health Insurance Portability & Accountability Act of 19996 ("HIPAA")is a federal program that requires that all medical records and other individually identifiable health insurance information used or disclosed by is in any from, whether electronically, on paper, or orally, are kept 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 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.

Health Care Operations include the business aspect of running our practice, such as conduction 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 non-identifiable health information by removing all reference to your identity such as before and after photographs of treatment procedures.

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

Any other uses and disclosures such as DHA children's "No Cavity Club" 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 offices:

- The right to request restrictions on certain uses and disclosure 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 request 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 or protected health information from us by alternative means of at alternative locations.
- The right to inspect and copy your protected health insurance.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The he right to obtain a paper copy of this notice from us upon request.

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 June 10, 2002 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 complaint with our office, or with the Department or Health & Human Services, Office of Civil Right, about Violations of the provisions of this notice of the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to Privacy Officer or for written inquiries, not "Attention Privacy Officer."

For more information about the HIPAA or to file a complaint;

The U.S. Department of Health & Human Services, Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
(202) 619-0257 | Toll Free: 1-877-696-6775

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

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

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly or indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address on the front of this acknowledgment document 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 out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such Restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

STATEMENT OF RESPONSIBILITY

The patient is responsible for notifying our office of any changes in address, telephone number(s), or insurance information. If the office is unable to contact you because of outdated or incorrect information, We cannot take responsibility for your care.

Patient Initials: _____

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. Please remember that your insurance policy is a contract between you and your insurance carrier. Co-payment are due at the time of service. Patients without insurance are expected to pay at the time the service is rendered.

Patient or Responsible Party Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

I authorize the release of all dental information to process insurance claims on my behalf. I authorize the assignment of benefit payment to which I am entitled to Dental Health Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient or Responsible Party Signature: _____ Date: _____