MOFFITT RESTORATIVE DENTISTRY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DISCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests 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, and the right to understand and control how your personal health information ("PHI") is used. HIPAA provided penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are to maintain the privacy of your health information and how we disclose your personal information.

We may use and disclose your PHI only for each of the following purposes; treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to another specialists or communicating with your general dentist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to an appointment.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessment, improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible. Examples of this would include an investigation of abuse or neglect, identification of a deceased person or cause of death; and activities related to national defense.
- Other instances where we may disclose PHI without consent or authorization of the patient include: communication with family, relatives, or close personal friends in an emergency: communication with the Food and Drug Administration regarding adverse events with respect to products and product defects: and communications pursuant to Workers' Compensation laws.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, 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 of your PHI will be made only with your written authorization under certain circumstances. 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 PHI.

- The right to request restrictions on the uses and disclosures of your PHI to carry out treatment, payment or health care operations: and the disclosures of your PHI to your family members, relatives, close personal friends or any other persons identified to you. We are, however, not required to honor a restriction except in limited circumstances which we shall explain to you if you ask. If we do agree to the restriction, we must abide by it unless and until the restriction agreement is terminated in writing by either party or in an emergency situation.
- The right to reasonable requests to receive confidential communications of PHI by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosure of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

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

This notice is effective the day this form was signed and we are required to abide by the terms of the Notice of Privacy Practice and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your privacy-rights have been violated by our office. You have the right to file a formal, written complaint with Moffitt Restorative Dentistry and with the Department of Health and Human Services, Office of Civil Rights with the information that is provided below. We will not retaliate against your for filing a complaint.

Feel free to contact our office for more information, in person or in writing. Contact information is:

Moffitt Restorative Dentistry
502 Jefferson Highway North
Champlin, MN 55316
Phone: 763-427-1311
www.MoffittRestorativeDentistry.com

Department of Health and Human Services
Office of Civil Rights
200 Independence Ave SW
Washington, D.C. 20201
Phone: 1-877-696-6775
https://www.HHS.gov

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I am a patient of Moffitt Restorative Dentistry. I hereby acknowledge receipt of Moffitt Restorative Dentistry's Notice of Privacy Practices.

Name (please print): _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ (patient name). I hereby acknowledge receipt of Moffitt Restorative Dentistry's Notice of Privacy Practices with respect to the patient.

Name (please print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____