NOTICE OF PRIVACY PRACTICES

OUR LEGAL DUTY

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices that are described in this Notice and will remain in the terms of this Notice effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made changes. Before we make a significant change in our privacy practices, we will change the Notice at any time. For more information about our privacy practices, or additional copies of Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provided to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professional, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you my revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patients Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree with written release on our Information Sharing Consent form.

Persons Involved in Care: We may use or disclose health information to notice, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional experience with common practice to make reasonable inferences of your best interest in allowing a person to pickup filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications

Required by Law: We will use of disclose your health information when we are required by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes.

National Security: We may disclose to military authorities the health information of Armed forces personnel under certain circumstances. We may disclose to authorized federal officials intelligence, counterintelligence and other nation security activities. We may dislose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcard , letter, text messages and/or e-mails).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. you may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure of Accounting: You have the right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment or healthcare operations and certain other activities, for the last 6 years.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (Must make your request in writing). Your request must specify the alternative means or location.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you received this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions/concerns, please contact using the information provided at the bottom of this notice. If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative locations. You may complain to us using the contact information listed at the end of this notice. You may submit a written complaint to the U. S Department of Health and Human services. We support your right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the U. S Department of Health and Human Services.

INNOVATIVE DENTISTRY
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ACKNOWLEDGEMENT OF RECEIPT/REVIEW OF NOTICE OF PRIVACY PRACTICES

Innovative Dentistry

I, _____, have received/reviewed a copy of Innovative Dentistry Notice Of Privacy Practices.

_____ _____
Signature Date

For Dependents Only (patients under the age of 18):

_____ _____
Print Name of Dependent Date

_____
Signature of responsible party

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to sign
_____Communication barriers prohibited obtaining the acknowledgement
_____An emergency situation prevented us from obtaining acknowledgement
_____ Other _____

_____ _____
Staff Signature Date

Information Sharing Consent Form

Innovative Dentistry

I, _____, give my permission to share information concerning:

- My dental treatment
- The cost and financial arrangements for my dental treatment
- My personal health information
- Other _____

I give my permission to share the above noted information with;

- My spouse (name) _____
- My Parent(s) (names) _____
- My adult child or children (names) _____
- Other _____

- I, _____, **DO NOT** give my permission to share **ANY** information regarding my treatment, financial arrangements or personal information with the exceptions of what is outlined in the Notice of Privacy Practices.

Signed: _____ Date:_____