Notice of Privacy Practices Acknowledgement

CONSTANCE CAMMAN, D.D.S.

7219 Sawmill Road, Suite 205

Dublin, Ohio 43016

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

o Conduct, plan and direct my treatment and follow-up among the multiple healthca;e providers who may be involved in that treatment directly and indirectly

o Obtain payment from third-party payers

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

Iacknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. Iunderstand that this organization has the right to change its *Notice of Privacy Practices* from time to *time* and th t Imay contact this organization at any time at t add*res* above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that Imay request in writing that you restrict how my private information *is* used or disclosed to carry out treatment payment or health care operations. Ialso 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:, \_

* The right to request restrictions on certain uses and disclosures of protected health infonnation, including hose 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 requested 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 of protected health infonnation from us by alternative means or at alternative locations.
* The right to inspect and copy your protected health infonnation.
* The right to amend your protected health infonnation.
* The right to receive an accounting of disclosures of protected health infonnation.
* The 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 infonnation and to provide you with notice of our legal duties and privacy practices with respect to protected health infonnation.

This notice is effective as of January 1, 2003 and we are required to abide by the tenns of the Notice of Privacy Practices currently in effect. We reserve the right to change the tenns of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health infonnation that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a fonnal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more infonnation: For more infonnation about HIPAA

or to file a complaint:

Privacy Officer

Connie Camman D.D.S. 3440 Olentangy River Road Columbus, Ohio 43202

614-262-6100

The U.S. Department of Health & Human Services Office of Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

(202) 619-0257

Toll Free: 1-877-696-6775

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**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 1996 \HIPAA") is a federal program that requires 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, 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.

If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

* Treatment means providing, coordinating, or managing health care and related services by one or more health care 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 for payment.
* Health care operations include the business aspects of running our practice, such as conducting 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 de-identified health information by removing all references to individually identifiable information. We may also conduct fundraising for our benefit.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or health care operations in the following circumstances:

* In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment;
* If we are required by law to treat you, and we attempt to obtain such consent but are unable to obtain such consent; or
* If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

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

Any other uses and disclosures 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 Officer.