

jeromeriddledds

Cosmetic and Family Dentistry

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected Health (PHI) information to carry out treatment, payment or, health information, re operations (TPO) and for other purposes permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information" is information about you, including demographics that may identify you and to your past, present or future physical or mental health and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosure of Protected Health Information;

Your protected health information may be used and disclosed by your physician, 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 your health care bills, to support the operation of the physician'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 health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval

For a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Options:

We may disclose, as-needed, your protected health information in order to support the business activities or your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. We may use a Sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician 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 your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses 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 You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

Following is a statement of your rights with respect to your protect your health information,

You have the rights to inspect and protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in a 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.

This means you may ask us not to use or disclose any part of your protected health information for the purposes 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 this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. The Physician believes it is your best interest to permit this and disclosure of you protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or an alternative location.
You have the right to Obtain a paper copy _____ form from us. upon request, even if you have agreed to accept this notice i.e. electronically

You may have the right to have your physician amend your protected health information. If we deny your request amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such a 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 complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by LB. You may file a compliant with us 'by notifying our privacy contact of your compliant. We will not retaliate against you for filing a compliant.

This notice was published and becomes effective Jan 1,2022.

We are required by law to maintain the privacy of, and provide individuals this, 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 our Main Phone Number.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature _____ Date: _____



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Cosmetic and Family Dentistry

Welcome! All of us at Dr. Riddle's office would like to take this opportunity to thank you for choosing us for your dental care. We are dedicated to the maintenance of good oral health and providing professional services to help maintain good health.

You may be assured our staff members are interested and concerned for your well being. We encourage open communication and are available to answer any questions regarding your condition and or financial arrangements.

Our financial policy is that payment is due on the date services are rendered. We will bill your insurance company as a courtesy to you and your family. Any portion applied by insurance as patient responsibility is due immediately upon insurance notification. Please be aware that you are ultimately responsible for any and all charges incurred as a result of services rendered, including any collection fees up to the amount of 40% of outstanding charges. In the event that your account is sent to collections, you agree to discuss your bill with the assigned agency.

If you find that you cannot keep your scheduled appointment, a 24 hour notice will allow us to schedule another patient in need of treatment. It is our policy that when a person misses their appointment or gives less than 24 hours notice there will be an "open chair fee". The open chair fee is \$50.00 per hour. We are not open on Friday – if appointment is on Monday please call by Thursday.

Patient or Parent

Signature _____

Date _____

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