

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable 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, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in 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 the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this Notice.

Uses and Disclosures of Health Information

We 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 dentist, physician or other healthcare provider providing treatment to you.

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

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

Michigan Dental Patient Consent Law: We are required by Michigan law to obtain your written consent prior to making certain disclosures of your health information.

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 may revoke it in writing at any time. Your revocation will not affect any use or 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 "Patient 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 that we may do so.

Persons Involved In Your Care: We may use or disclose health information to notify, or assist in the notification of (including identifying and 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 judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up 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 without your written authorization.

Required by Law: We may use or disclose your health information when we are required by law to do so.

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. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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

Contact: We may use or disclose your health information to provide you with voicemail messages, postcards or letter appointment reminders, or newsletter

Patient Rights

Access: You have the right to look at or obtain copies of your health information, with limited exceptions. You may request that we provide copies of your health information, either as photocopies or in some other available format. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information or may obtain a form from this practice to request access). There will be a reasonable fee for photocopying or for an alternative format.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we will charge you additional fees for the additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, although we are not required to agree to these additional restrictions. If we do, in writing, we will abide by our agreement, except in an emergency.

Alternative Communication: You have the right to request, in writing, that we communicate with you about your health information by alternative means or to alternative locations. Your written request must specify the alternative means or location and provide a satisfactory explanation of how payments will be handled under the alternative means or location that you request.

Amendment: You have the right to request, in writing, that we amend your health information, although we may deny your request under certain circumstances. You must include in your request an explanation of why the information should be amended.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact our office. If you are concerned that we may have violated your privacy rights in reference to anything stated above, you may submit a written complaint to us and/or to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to privacy and will not retaliate in any way if you choose to file a complaint.

Dr. Josephine C. Weeden 615 Bent Oak Ave., Adrian, MI 49221 (517)263-1563



**Josephine
C. Weeden** D.D.S.,
M.S., P.C.
Specialist In Orthodontics
& Dentofacial Orthopedics

**Acknowledgement of Receipt of
"Notice of Privacy Practices"**

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires us (in addition to our attempt to obtain your written acknowledgement, discussed above) to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time, it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

You have the right to refuse to sign this acknowledgement.

Please sign this form below to acknowledge that you have today received a copy of the "Notice of Privacy Practices".

I acknowledge that I have today received a copy of the "Notice of Privacy Practices".

I am the patient, custodial parent of this patient, legal guardian of this patient _____

Signature: _____ Date: _____

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

Office Personnel Signature

Office Personnel Name (please print)

Date

Patient Privacy Consent
Dr. Josephine C. Weeden
615 Bent Oak Ave., Adrian, MI 49211, (517) 263-1563

Patient's Name: _____ Case # _____

- It is our policy to comply with federal and state regulations with regard to patient privacy. We will protect your privacy in our communications with you, your family dentist, other health care professionals that we work with who are treating you, your insurance companies, third party financing companies, and whomever we mutually work with to provide you with the highest level of care.
- When this patient's information is sent electronically or by mail, we will do all that is reasonably possible to make sure that it is only sent to associated health care professionals or to specific individuals involved in electronic processing of insurance claims. When sent, we will do all that is reasonably possible to make sure that only the minimal information is sent.
- We will use the patient's health history, initial interview, doctor exam and initial diagnostic records to understand the patient's present state of health, to determine the patient's sensitivity to various materials, drugs and the environment, to help diagnose the patient's orthodontic and orofacial problems, and to refer back to as treatment progresses.
- During treatment, we will be sending this patient's primary dentist copies of the progress reports we give to you. When necessary, we will be sending related health care professionals records with requests for treatment (for example, general dental, periodontal, endodontic, oral surgery, etc., and also possible physician referrals if the patient is presently under a physician's care)
- When communicating with you about problems or complications in treatment, we will make every reasonable effort to protect your privacy.
- When communicating with third party financing, including your orthodontic insurance companies and other third party payers (bank loans, credit cards, etc.) we will make every reasonable effort to provide them with the minimal information required to help you finance your treatment. In many cases, you will provide the information instead of us.
- This patient's hardcopy records and diagnostic records will be filed in this patient's records folder, or when electronically filed, it will be filed in a password-protected computer system. We will do all that is reasonably possible to make sure that this information is only accessible to the doctors and team members who use that information in the care of this patient.
- Those with access to this patient's records are: the patient, custodial parents or legal guardians and in the case of divorce to the non-custodial parent with proper identification. There will be a fee to duplicate this patient's records.
- A copy of this policy will be kept on file should you require a copy at any time. If policies change, you will be notified of the changes.
- You have the right to revoke your consent in writing at any time, but this will not affect what has occurred before that revocation.
- You have the right to read the entire "Notice of Privacy Practices" before signing this consent form if you desire.

I am the <input type="checkbox"/> patient <input type="checkbox"/> custodial parent of this patient <input type="checkbox"/> legal guardian of this patient: _____			
Signature: _____		Date: _____	
I consent to this practice sending periodic reports and notifications to this patient's dentist and physician as needed for the proper care of this patient.	Initial if yes: _____	I consent to this practice using this patient's diagnostic and other records (excluding the medical history) for educational purposes.	Initial if yes: _____
I consent to this practice providing my insurance company with necessary records in order to obtain payment for orthodontic treatment.	Initial if yes: _____	I consent to this practice displaying photographs or using the name of this patient on computer displays and on office bulletin boards.	Initial if yes: _____