STRAIT SMILES
FAMILY DENTISTRY

Strait Smiles Family Dentistry

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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. HIPPA 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 may 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 a surgery.
- 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, text, email, 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 circumstance. 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 you PHI to your family members, relatives, close personal friends or any other persons identified by you. We are, however, not required to honor a restriction request 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 alternative 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 disclosures 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 as of November 12, 2012 and we are required to abide by the terms of the Notice of Privacy Practices 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 Strait Smiles Family 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 you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing. Contact information is:

Strait Smiles Family Dentistry
Attn: Dr. Tasha Strait
201 West Raven Street
Belle Plaine, MN 56011
Phone: 952-873-6380
E-mail: straitsmiles@straitsmiles.net

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

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I am a patient of Strait Smiles Family Dentistry. I hereby acknowledge having been offered Strait Smiles Family Dentistry's Notice of Privacy Practices.

Name: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Strait Smiles Family Dentistry's Notice of Privacy Practices with respect to the patient.

Name: _____

Relationship to the Patient: ☐ Parent ☐ Legal Guardian ☐ Power of Attorney

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 on the lines provided below).

_____

_____

*** This form is educational only, it does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

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PATIENT COMMUNICATION FORM

Family and Friends: It is the office guidelines of Strait Smiles Family Dentistry not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please circle the "**no**" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

You may cancel this authorization to the extent allowed by law. If you do, you understand that the doctor or practice may have already released information about you after you gave permission. You understand that canceling this authorization would not prohibit any release of information by the practice in reliance on your original authorization. If you wish to cancel or change this agreement please call Strait Smiles Family Dentistry or issue a letter in writing.

	Health Care Information		*Financial Information*	
Any family member or any caregiver with patient is allowed to receive information	Yes	No	Yes	No
Spouse:	Yes	No	Yes	No
Parent:	Yes	No	Yes	No
Other:	Yes	No	Yes	No
_____	Yes	No	Yes	No

Alternative Communications: You are entitled to specify alternative, reasonable means of communication, if you do wish to be contacted by us in a certain way.

I hereby request the following contact only: _____

_____

_____

Printed Name: _____ Date: _____

Patient/Parent/Guardian Signature: _____

FOR OFFICE USE ONLY

Changes to above, authorized by patient over the phone.

Change	*Date*	*Staff Initials*
_____	_____	_____
_____	_____	_____

Form Updated 2014