

Marshall Dental

Notice of Privacy Practices for Protected Health Information

Effective Date: April, 2012

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 office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

During the course of your treatment, the doctor determines he/she will need to consult with another specialist in the area. He/She will share the information with such specialist and obtain his/her input.

Examples of Use of Your Health Information for Payment Purposes:

We submit requests for payment to your insurance company. The insurance company (or other business associate helping us obtain payment) requests information from us regarding to them about you and care given.

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

Request a restriction on certain uses and disclosures of your health information by delivering the request to our office -- we are not required to grant the request, but we will comply with any request granted;

Request a restriction on disclosures of medical information to a dental health plan for purposes of carrying out payment or dental health care operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a dental health care service for which the provider has been paid out of pocket in full --We must comply with this request;

Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;

Appeal a denial of access to your protected health information, except in certain circumstances;

Request that you be allowed to inspect and copy your record and billing record - you may exercise this right by delivering the request to our office;

Request that your record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendments;
- Is not part of the health information kept by or for the office;
- Is not part of the information you would be permitted to inspect and copy; or,
- Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;

Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosure of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.

Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office/hospital, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact the office at 159 Lichfield Blvd, Suite 107, Fredericksburg, VA 22406 (540) 373-2273, in person or in writing, during regular, business hours. [S]he will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities: The office is required to

- Maintain the privacy of your health information is required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If you information practices changes, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint:

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the office @ 540-373-2273.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Marshall Dental, 159 Lichfield Blvd, Suite 107, Fredericksburg, VA 22406.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.

-We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

* I have read and understand my rights. I understand I have been given the option to have a copy for my records.

* By checking this box, I acknowledge that I have read this statement and agree to the contents.

Signature: _____

Date:

Response Date: