

PREMIER DENTISTRY

COSMETIC, RESTORATIVE, AND SEDATION DENTISTRY

NOTICE OF PRIVACY PRACTICES AND PATIENT ACKNOWLEDGMENT

To our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training to that they may understand and comply with the government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA), with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity when providing services to our patients.

It is our policy to properly determine the appropriate use of PHI in accordance with governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that will help us prevent any inappropriate use of PHI.

It is our policy to listen to our employees and our patients without any risk of penalization if they feel that an even in any way compromises our policy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a Privacy Rule to help ensure that personal health information is protected for privacy. The Privacy Rule provides the rules that must be followed prior to disclosing health information about the patient that is needed to carry out treatment, payment, or health care operations.

We want you, our patients, to know that we respect the privacy of your personal medical records and will do all that we can to secure and protect your privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum information necessary only to those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions to parties to whom you do not want PHI released. You will be asked to authorize release of PHI to any party who is not directly connected to your treatment, payment, or health care operations.

If you have any questions, comments, or objections to the privacy policies on this form, please speak with one of our staff.

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Cosmetic, Restorative, and Sedation Dentistry

ASSURANCE OF PRIVACY (HIPAA)

**PLEASE SIGN THIS FORM TO ACKNOWLEDGE THAT YOU HAVE
READ THE ASSURANCE OF PRIVACY**

Patient's Name (printed)

Patient's Signature

Date

If you have any questions, comments, or objections to the privacy policies on the attached letter, please ask to speak with our compliance officer. You have the right to review the entire privacy policy manual upon request.

Please provide the name, relationship, and telephone number of the proxy whom you wish to request information and/or speak on your behalf.

Proxy's Name (printed)

Relationship

(_____) – (_____) – (_____)

Phone Number

Authorized Signature of Patient