Privacy Practices Overview

Purpose: This office is committed to compliance with all federal and state laws that pertain to any aspect of the clinical practices or business procedures of this office. In particular, privacy and security rules relating to the Health Insurance Portability and Accountability Act (HIPPA), along with related state laws, are integral to matters of privacy, medical records, the confidentiality of communications, and other topics addressed throughout this policy and procedure manual.

Policy: The HIPPA Privacy Rule applies to all protected health information (PHI) in this office, including information stored and transmitted electronically, paper records and oral communications. PHI includes any information as it relates to the past, present, or future physical or mental health condition of any of our patients; any treatment they have received; and health care payment information.

.In keeping with HIPPA compliance this office has appointed a Private Officer to continually evaluate our privacy practices, train our staff about privacy issues, supervise the sharing of information with third parties, and address any complaints from patients, their friends, their loved ones, staff, other providers, or members of the community.

.All staff members will be trained on this policy and procedure manual, which will help ensure that the procedures in effect in our office are in keeping with both state and federal law. The Privacy Officer is responsible for both the training of staff as well as continual review and amendment of this manual as necessary.

.A Notice of Privacy Practices is reviewed by all patients to increase their understanding of how their PHI is stored, used and shared beyond this practice, and to notify them of their new rights created under HIPPA.

.Under all circumstances, when PHI must be communicated either within this office or to a third party, only the amount of information that is minimally necessary to accomplish the appropriate purpose will be divulged. The Privacy Officer is responsible for establishing criteria on what information is minimally necessary for recurring situations. Unusual or unique needs to share information will be conveyed to the Privacy Officer for approval.

.PHI that is shared as part of delivering quality patient care will not be scrutinized under the minimally necessary guidelines and any information necessary for quality care will be shared appropriately.

.Only those medical records and fields that are immediately necessary for patient care are to be kept at workstations.

.In this office we remind patients of their office visits via mail, phone, leaving messages on their answering machine or family members if they are not available. We also occasionally send out mail notices of notices of seasonal specials.

.Please provide your initials below if you DO NOT wish to have us include you in any of these office policies and list items that you desire to be excluded from.

DO NOT include me in the following:

_____

_____Initial_____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Privacy Practices Overview, which is a condensed explanation of how my medical information will be used and disclosed. I understand that there is a complete Notice of Privacy Practices that is available and I am entitled to receive a copy of this document.

Print Name: _____Signature of Patient/Parent/Guardian: _____Date _____

PATIENT CONSENT FOR USE and DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 01 ,2013

West Creek Dental may disclose and use protected health information (PHI) about me to carry out treatment, payment and healthcare operations. Please refer to the Notice of Privacy (NOF) for a more comprehensive description of such disclosure and uses.

I have the right to review the NOF prior to signing this consent and West Creek Dental may revise its NOF at any time. A revised NOF may be obtained through written request to our office.

West Creek Dental may call my home or other designed location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and operations, such as appointment reminders, insurance items and any call pertaining to my care.

West Creek Dental may mail to my home or other designated location any items that assist the office in carrying out treatment, payment and operations as long as they are marked Private and Confidential.

By signing this form I am consenting to West Creek Dental the disclosure and use of my PHI to carry out treatment, payment and operations. I may withdraw my consent in writing except to the extent that the office has already made disclosures and reliance upon my prior consent.

If I do not sign this consent, West Creek Dental may decline to provide dental care to me.

Print Name _____ Signature of Patient/Parent/Guardian _____Date_____