

# SMITHFIELD COMPREHENSIVE & COSMETIC DENTISTRY

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## NOTICE OF PRIVACY PRACTICES

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

**THESE ARE FEDERAL REGULATIONS. PLEASE REVIEW THEM CAREFULLY.**

**PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

### **OUR LEGAL DUTY**

We are required by applicable federal 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 the Notice while it is in effect. This Notice takes effect 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the 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 the Notice and make the new Notice available upon request. You may request a copy of our Notice at anytime. For more information about our privacy practices, or for additional copies of the Notice, please contact us by using the information listed at the end of this Notice.

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### **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 for you.

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

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include 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.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorizations 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 anytime. 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 the Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of the 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 Care:** We may disclose health information to notify, or assist in the notification of (including identifying or 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 fill prescriptions, medical supplies, x-rays, other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications.

**Broken Appointment Fee:** We reserve the right to charge **\$55.00** per broken appointment without a 48 hour notice of cancellation.

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

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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#### **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. (You must make a request in writing to obtain access to your health information. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you **\$35.00** for the most recent and pertinent radiographs or up to **\$75.00** (which ever is the least) for a copy of the complete chart for staff time to locate and copy your health information, and postage if you want the copies mailed to you).

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

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

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#### **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to the U.S. Department of Health and Human Services.

**Contact Officer: Nancy Campbell**

**Telephone: (919) 934-3636 Fax: (919)934-1667**

**Address: 415-B North Seventh Street**

**Smithfield, NC 27577**

# SMITHFIELD COMPREHENSIVE & COSMETIC DENTISTRY

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**FEDERALLY MANDATED REGULATIONS REQUIRE THAT WE  
PROVIDE YOU WITH THIS INFORMATION. THANK YOU FOR  
ATTENTION AND COOPERATION IN THIS MATTER.**

I, \_\_\_\_\_, have received a copy of this office's Notice  
of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### 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

Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# SMITHFIELD COMPREHENSIVE & COSMETIC DENTISTRY

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## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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### SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient #: \_\_\_\_\_ Social Security: \_\_\_\_\_

### SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected information to carry out treatment, payment activities, and healthcare operations that are directly related to your health.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Nancy Campbell

Telephone: (919)934-3636 Fax: (919) 934-1667

Address: 415-B NORTH SEVENTH STREET, SMITHFIELD, NC 27577

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Listed Above. Please understand that revocation of the Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

### SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT FORM AFTER YOU SIGN IT.**

### REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_