Partrick Orthodontics

NOTICE OF PRIVACY POLICIES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI) and private health information (PHI). In conducting our business, we will create records regarding you and the treatment services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI/PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make 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 amend this Notice and make the new Notice available upon request.

B. USES AND DISCLOSURES OF HEALTH INFORMATION

The following categories describe the different ways in which we may use and disclose your IIHI/HPI.

1. Treatment: Our practice may use your IHI/PHI to treat you. (For example, we may request lab tests, pathology tests and use the results for further treatment. We may write prescriptions for you and telephone them into your pharmacy. Many of the staff who work for our practice – including, but not limited to, our doctors, staff and assistants – may use or disclose your IIHI in order to treat you or to assist other healthcare workers in your treatment. Additionally, we may disclose your IIHI/PHI to others who may assist in your care, such as your spouse, children, or parents (with proper consent). Finally, we may also disclose your IIHI/PHI to other health care providers for purposes related to your treatment, including digital transmissions.

2. Payment: Our practice may use and disclose your IIHI/PHI in order to bill and collect payment for the services and items you may receive from us. (For example, we may contact your health insurer to verify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI/PHI to obtain payment from third parties that may be responsible for such costs, such as family members. We may use your IIHI/PHI to bill you directly for services. We may disclose your IIHI/PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations: Our practice may use and disclose your IIHI/PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI/PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning-activities for our practice. We may disclose your IIHI/PHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders: Our practice may use and disclose your IIHI/PHI to contact you and remind you of an appointment (via automated voice reminder, appointment cards, voice mail messages, letters).

5. Treatment Options: Our practice may use and disclose your IIHI/PHI to inform you of potential treatment options or alternatives.

6. Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your

authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including or 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 written consent by the patient will be obtained prior to any disclosure. 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 interferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

7. Miscellaneous: We may disclose your health information to appropriate authorities when required to do so by law, regarding abuse or neglect to military authorities under certain circumstances (lawful intelligence, counter-intelligence or other natural security activities), or to a correctional institution that has lawful custody of PHI of an inmate or patient under certain circumstances.

C. PATIENT RIGHTS

1. Access: You have the right to look at or obtain copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information). You may obtain a form to request access from the front staff and forward the document to the Privacy Officer at the address below. If you request copies. The charge for this service will be up to $10 up to 20 pages, $20 for 21 pages or over, or $20 for any dictated notes by the doctor. Any other format will be at a cost-based fee for providing your health information in that format if we have the resources to do so.

2. Disclosure Accounting: You have the right to receive a list of instances in which we have disclosed IIHI/PHI for non-routine disclosures our practice has made for non-treatment, non-payment or non-operation purposes. In order to obtain an accounting of this information, this must be made in writing to the Privacy Officer, this disclosure must state a specific time period, which may not be longer than six (6) years from the date of disclosure and may not include dates prior to April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved and you may withdraw your request before you incur any costs.

3. Restrictions: You have the right to request additional restrictions on your health information in writing, but we are not required to agree to these additional restrictions. If we do, we will abide by our agreement (except in an emergency).

4. Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

D. QUESTIONS AND COMPLAINTS

If you believe your privacy rights have been violated, you may file a written complaint with our practice (Privacy Officer) or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Send all questions or concerns in writing to Privacy Officer, Partrick Orthodontics, 2310 Myron Drive, Raleigh, NC 27607. We have 30 days to respond in writing to any requests, complaints or concerns.

Consent for Use and Disclosure of Health Information

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

Notice of Privacy Policies: You have been given a copy of our Notice of Privacy Policies. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the sues and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of ou 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 Maura H. Partrick, DDS, MS, PA, phone 919-469-9609, fax 919-238-4843, 2310 Myron Drive, Raleigh, NC 27607.

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to Dr. Partrick (contact information above). Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

You are entitled to a copy of this consent after you sign it.

I, _____, have had full opportunity to read and consider the consents of this.
Printed Name
Consent form and have received a copy of Partrick Orthodontics' Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to you Partrick Othodontics' use and disclosure of my Protected Health Information to carry out treatment, payment activities and health care operations.

Authorization to pay Benefits to Partrick Othodontics/Authorization to release Medical Information

I authorize payment directly to Partrick Orthodontics should Dr. Partrick agree to accept assignment of benefits. I authorize Partrick Orthodontics to release my information required in the course of my claims or related services.

_____ _____
Signature Date

_____
Address: Street, City, State, Zip

_____ _____
Telephone Chart #

If this Consent is signed by a parent/guardian, complete the following:

Parent/Guardian's Name: _____

Relationship to Patient: _____