

FAMILY DENTAL CENTER, P.C.

116 JACK WHITE DR., SUITE 12

KINGSPORT, TN 37664

(423) 247-6961

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ THIS NOTICE CAREFULLY.

OUR LEGAL DUTY

We are required by applicable federal and 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 this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it. 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. You may request a copy of our Notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment: In conjunction with any healthcare provider providing treatment to you.

Payment: To obtain payment for services we provide to you.

Healthcare Operations: In connection with our healthcare operations for administrative purposes to efficiently and effectively run our practice.

Your Authorization: We may need to use or disclose your health information to others concerning appointment confirmation, information about treatment, or other health related information that may be of interest to you. You may give us written authorization to do so. If you give us written authorization, you have the right to revoke it at anytime.

To Your Family Friends: With your written authorization, we may disclose information to a family member, friend, or other person to the extent necessary to aid you with healthcare or payment.

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

Abuse or Neglect: If reasonable evidence points to possible abuse, neglect, domestic violence, or other crimes we reserve the right to report the matter to the proper authorities to insure your safety.

PATIENTS RIGHTS

Your rights under this Notice are as follows:

Access: To look at or get copies of your health information with limited exceptions. You must make this request in writing. A reasonable fee may be charged for expenses such as copies and staff time.

Disclosure Accounting: To receive a list of instances in which your information was disclosed, other than treatment, payment, and healthcare operations for the last 6 years, but not before April 14, 2003.

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

Amendment: To request that we amend your health information. The request must be in writing, and it must explain why it should be amended. We may deny the request under certain circumstances.

Complaints: To complain to us or to the Department of Health and Human Services if you feel your privacy rights have been violated. While you may make an oral complaint at any time, written comments should be addressed to the above address.

FAMILY DENTAL CENTER, P.C.
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of Family Dental Center's
Notice of Privacy Practices.

Please Print Name

Signature

Date

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.
- _____ Communication barriers prohibited obtaining the acknowledgement.
- _____ An emergency situation prevented us from obtaining acknowledgement.
- _____ Other (Please Specify)

PATIENT CONSENT AUTHORIZATION

I authorize Family Dental Center to leave messages regarding appointment information on my answering machine in the event that I cannot be reached by phone.

Yes _____ No _____

I authorize Family Dental Center to leave a message with the following listed people at my home.

I authorize Family Dental Center to call me at work.

Yes _____ No _____

I authorize Family Dental Center to leave a message for me at work with the following listed people.

I authorize Family Dental Center to discuss my treatment with the following listed people.

Who can Family Dental Center discuss financial information and/or arrangements with?

I authorize Family Dental Center to send correspondence by mail to my home such as appointment reminders, office updates, etc...

Yes _____ No _____

Please Print Name

Signature

Date