ARROW DENTAL CARE, L.L.C.
DISCLOSURE OF PRIVACY PRACTICES

BILLING: We will only release to third party billing entities and your dental insurance carrier(s) that information that is required to bill you, or secure insurance benefits on your behalf. All billing and insurance information released by this office is done so using a secure electronic transmission vehicle that complies with federally mandated HIPAA privacy guidelines.

HEALTHCARE PROVIDER DISCLOSURE: We will release to dental specialists and your personal physician(s) only that information that is required to: 1) secure specialty treatment, 2) confirm your dental health prior to medical treatment that could be compromised by your dental health condition, 3) facilitate emergency medical treatment or 4) refer you for evaluation of a serious medical condition discovered during the delivery of your dental care in this office.

MARKETING OF HEALTH RELATED SERVICES: We will not use your confidential health information for marketing communications without your written permission.

REQUIRED BY LAW: We may only use or disclose your health information when required by law to do so.

ABUSE OR NEGLECT: We may disclose your health information to the appropriate authorities if we reasonably believe you are the possible victim of abuse, neglect or domestic violence, or the possible victim of another crime. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health and safety of others.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voice mal messages, postcards or letters).

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<u>PATIENT RIGHTS</u>

ACCESS: You have the right to look at or get 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 predictably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses, such as copies or staff time. 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 $.10 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the records mailed to you. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

DISCLOSURES AND ACCOUNTING: You have the right to receive a list of instances in which we, or our business associates, disclose your health information for purposes other than treatment payment, health operations and certain other activities, for at least six (6) years, but not before June 1, 2009. If you request this information more than once in a twelve (12) month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTIONS: You have the right to request we place additional restrictions on our use 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 COMMUNICATIONS: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. <u>Requests of this type must be made in writing</u>. Your request must specify the alternative means or location, and provide satisfactory explanation of how payment will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. <u>Your request must be in writing and it must explain why the information should be amended.</u>

ELECTRONIC NOTICES: If you receive this Notice on our website, or by electronic mail (email) you are entitled to receive the Notice in written form.

All requests for your confidential health information should be directed to:

Matthew J. Howard, D.D.S.
HIPAA Compliance Officer
c/o Arrow Dental Care, L.L.C.
15623 Manchester Road, Ste. 100
Ellisville, MO 63011-2495
Phone: (636) 220-7770
Fax: (636) 222-7962

I acknowledge that I have read the above information regarding the use of my confidential health information by Arrow Dental Care, L.L.C. and understand the guidelines I must follow to obtain, transfer or amend my health information.

_____ _____

Signature of Patient or Patient's Legal Guardian **Date**

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Name of Legal Guardian (Please Print)

I also give permission to Arrow Dental Care, L.L.C. . to disclose my confidential personal and health information to the following individuals only:

Names	**Relationship to Patient**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Signature of Patient or Patient's Legal Guardian **Date**

_____

Name of Legal Guardian (Please Print)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of our Disclosure of Privacy Practices, but Acknowledgment could not be obtained because:

- □ **Patient or Legal Guardian refused to sign the acknowledgement**
- □ **Communication Barrier prohibited obtaining the acknowledgement**
- □ **An emergency situation prohibited us from obtaining the acknowledgement**
- □ **Other (please specify):**

_____
_____
_____
_____
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