Effective 2013

HIPAA NOTICE OF PRIVACY PRACTICES

for the Healthcare Facility of:
Galleria Dentistry
9140 Galleria Court
Naples, FL 34109

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION under the HIPAA Omnibus Rule of 2013.

PLEASE REVIEW IT CAREFULLY

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

RULES ON HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Under the law, we must have your signature on a written, dated Consent Form and/or an Authorization Form of Acknowledgement of this Notice, before we will use or disclose your PHI for certain purposes as detailed in the rules below.

Documentation – You will be asked to sign an Authorization / Acknowledgement form when you receive this Notice of Privacy Practices. If you did not sign such a form or need a copy of the one you signed, please contact our Privacy Officer. You may take back or revoke your consent or authorization at any time (unless we already have acted based on it) by submitting our Revocation Form in writing to us at our address listed above. Your revocation will take effect when we actually receive it. We cannot give it retroactive effect, so it will not affect any use or disclosure that occurred in our reliance on your Consent or Authorization prior to revocation (i.e. if after we provide services to you, you revoke your authorization / acknowledgement in order to prevent us billing or collecting for those services, your revocation will have no effect because we relied on your authorization/ acknowledgement to provide services before you revoked it).

General Rule – If you do not sign our authorization/ acknowledgement form or if you revoke it, as a general rule (subject to exceptions described below under "Healthcare Treatment, Payment and Operations Rule" and "Special Rules"), we cannot in any manner use or disclose to anyone (excluding you, but including payers and Business Associates) your PHI or any other information in your medical record. By law, we are unable to submit claims to payers under assignment of benefits without your signature on our authorization/ acknowledgement form. You will however be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under the new Omnibus Rule. We will not condition treatment on you signing an authorization / acknowledgement, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the authorization/ acknowledgement or revoke it.

A. Healthcare Treatment, Payment and Operations Rule

With your signed consent, we may use or disclose your PHI in order:

1. **Treatment** - To provide you with or coordinate healthcare treatment and services. For example, we may review your health history form to form a diagnosis and treatment plan, consult with other doctors about your care, call in prescriptions to your pharmacy, disclose needed information to your family or others so they may assist you with home care, arrange appointments with other healthcare providers, etc.

2. **Payment** - To bill or collect payment from you, an insurance company, a managed-care organization, a health benefits plan or another third party. For example, we may need to verify your insurance coverage, submit your PHI on claim forms in order to get reimbursed for our services, obtain pre-treatment estimates or prior authorizations from your health plan or provide your x-rays because your health plan requires them for payment; Remember, you will be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under this new Omnibus Rule.

3. **Health Care Operations** - To run our office, assess the quality of care our patients receive and provide you with customer service.

4. **Appointment Reminders** - We may contact you by telephone, mail or otherwise remind you of scheduled appointments, we

may leave messages with whomever answers your telephone or email to contact us (but we will not give out detailed PHI), we may call you by name from the waiting room, we may tell you about or recommend health-related products and complementary or alternative treatments that may interest you. If you prefer that we not contact you with appointment reminders or information about treatment alternatives or health-related products and services, please notify us in writing at our address listed above and we will not use or disclose your PHI for these purposes.

5. **Release of Information to Family/Friend** - Our practice may release your PHI to a family member or friend that is involved in your care, or who assists in taking care of you.

6. **Disclosures Required by Law** – Our practice will use and disclose your PHI when we are required to do so by Federal, State, or Local Law.

B. <u>Use and Disclosure of your PHI in Certain Special Circumstances</u>

1. **Public Health Risks** – Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
   - Maintaining vital records, such as births and deaths
   - Reporting child abuse or neglect
   - Preventing or controlling disease, injury or disability
   - Notifying a person regarding potential exposure to a communicable disease
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - Reporting reactions to drugs or problems with products or devices
   - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.

2. **Health Oversight Activities** – Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings** – Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in a dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information by the party requested.

4. **Law Enforcement** - We may release PHI in asked to do so by law enforcement officials:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
   - Concerning a death we believe has resulted from criminal conduct
   - Regarding criminal conduct at our office
   - In response to a warrant, summons, court order, subpoena or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - In an emergency to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. **Deceased Patient** – Our practice may release PHI to a medical examiners or coroners to identify deceased persons or determine cause of death. If necessary, we may also release information for a funeral directors to perform their jobs.

6. **Organ and Tissue Donation** - For organ and tissue donation (i.e. if you are an organ donor, we may release your PHI to organizations that handle organ, eye or tissue procurement, donation and transplantation)

7. **Research** - For research projects approved by an Institutional Review Board or a privacy board to ensure confidentiality (i.e. if the researcher will have access to your PHI because involved in your clinical care, we will ask you to sign an authorization)

8. **Serious Threats to Health or Safety** - When necessary in emergencies to prevent a serious threat to your health and safety or the health and safety of other persons

9. **Military** – Our practice may disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National Security**- Our practice may disclose your PHI to federal officials for intelligence, counterintelligence or other national security activities authorized by law.

11. **Inmates** – Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers Compensation** - For Worker's Compensation purposes (i.e. we may disclose your PHI if you have claimed health benefits for a work-related injury or illness)

C. **Your Rights Regarding Your PHI**

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential Communications** - You may ask us to communicate with you in a different way or at a different place. In order to request this you need to submit a written request to the Office Manager, specifying the request method of contact, or the location where you wish to be contacted. We will not ask you why and we will accommodate all reasonable requests. (which may include: to send appointment reminders in closed envelopes rather than by postcards, to send your PHI to a post office box instead of your home address, to communicate with you at a telephone number other than your home number). You must tell us the alternative means or location you want us to use and explain to our satisfaction how payment to us will be made if we communicate with you as you request.

2. **Requesting Restrictions** - You may ask us to limit how your PHI is used and disclosed by submitting a written request to the Office Manager (i.e. you may not want us to disclose certain information to family members or friends involved in paying for our services or providing your home care). **We are not required to agree to your request;** if we do agree to these additional limitations, we are bound by our agreement except when otherwise required by law, in emergencies (where we will not have time to check for limitations), or when the information is necessary to treat you. Your request must describe in clear in writing the following:
    - The information you wish to restrict
    - Whether you are requesting to limit our practice's use, disclosure or both
    - To whom you want the limitations to apply to

3. **Inspection and copies** - You have the right to see and get a copy of your PHI that may be used to make decisions about you including patient medical and billing records. You have the right to receive electronic copies of your information if the records are readily reproducible in that format. You must submit a written request to our Office Manager in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews. Original records will not leave the premises, will be available for inspection and/or copy only during our regular business hours, and only if our Office Manager is present at all times.

4. **Amendment** – You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Office Manager. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete, (b) not part of the PHI kept by or for our practice, (c) not part of the PHI which you would be permitted to inspect and copy, or (d) not created by our practice, unless the individuals or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures** - All of our patients have the right to request an "Accounting of Disclosures" An "Accounting of Disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purpose. Use of your PHI as part of the routine patient care in our practice is not required to be documented. In order to obtain an accounting of disclosures, you must submit in writing your request to the Office Manager. All requests for an "Accounting of Disclosures" must state a time period, which may not be longer than six years from the date of disclosure. The first list you request within a 12 month period is free of charge, but our practice may charge you for additional list within the same 12 month period. Our practice will notify you the cost involved and let you choose if you want to withdraw or modify your request to avoid the cost.

6. **Right to paper copy of This Notice-** You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time.

7. **Right to File a Complaint** – If you believe your privacy rights have been violated, you may file a complaint with our practice, contact **Galleria Dentistry, Att: Privact Officer, 9140 Galleria Court Naples, Florida 34109.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. **Right to Provide an Authorization for Other uses and Disclosures-** The following uses and disclosures will be made only with the authorization from you: (a) most uses and disclosures of psychotherapy notes, (b) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications, (c) disclosures that constitute a sale of PHI, and (d) other uses and disclosures not described in the NPP.

   Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care.

9. **Notification of Breach-** We are required to notify you of any breach of your unsecured PHI.

10. **Fundraising -** We will inform you of our intentions to raise funds and your right to opt out of receiving such communications.

11. **Out-of-Pocket Services** – If you pay for your services out-of-pocket, in full, you have the right to request that we do not disclose your PHI, related solely to those services, to your health plan. You are required to notify a Business Associate and a downstream Health Information Exchange of this restriction.

12. **Collections -** If we use or disclose your PHI for collections purposes, we will do so only in accordance with the law.

13. **Inactive Patient Records -**We will retain your records for seven years from your last treatment or examination, at which point you will become an inactive patient in our practice and we may destroy your records at that time (but records of inactive minor patients will not be destroyed before the child's eighteenth birthday). We will do so only in accordance with the law (i.e. in a confidential manner, with a Business Associate Agreement prohibiting re-disclosure if necessary).

14. **Business Associate Rule -** Business Associates are defined as: an entity, (non-employee) that in the course of their work will directly/indirectly use, transmit, view, transport, hear, interpret, process or offer PHI for this Facility.

    Business Associates and other third parties (if any) that receive your PHI from us will be prohibited from re-disclosing it unless required to do so by law or you give prior express written consent to the re-disclosure. Nothing in our Business Associate agreement will allow our Business Associate to violate this re-disclosure prohibition. Under Omnibus Rule, Business Associates will sign a strict confidentiality agreement binding them to keep your PHI protected and report any compromise of such information to us, you and the United States Department of Health and Human Services, as well as other required entities. Our Business Associates will also follow Omnibus Rule and have any of their Subcontractors that may directly or indirectly have contact with your PHI, sign Confidentiality Agreements to Federal Omnibus Standard.

15. **Changes to Privacy Policies Rule -** We reserve the right to change our privacy practices (by changing the terms of this Notice) at any time as authorized by law. The changes will be effective immediately upon us making them. They will apply to all PHI we create or receive in the future, as well as to all PHI created or received by us in the past (i.e. to PHI about you that we had before the changes took effect). If we make changes, we will post the changed Notice, along with its effective date, in our office and on our website. Also, upon request, you will be given a copy of our current Notice.

Again, If you have any questions regarding this notice or our health information privacy policies; please contact **Galleria Dentistry, Att: Privact Officer, 9140 Galleria Court Naples, Florida 34109.**

Galleria Dentistry
9140 Galleria Court
Naples, FL 34109-4343

www.galleriadentistry.com
(239)592-5112
info@galleriadentistry.com

Patient Acknowledgement of Receipt of Notice of Privacy Practices and Consent / Limited Authorization and Release Form

You may refuse to sign this acknowledgement and authorization. In refusing we may NOT be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

Signature: _____ Date: _____

Please print name /or name of signer if not patient and relationship to patient

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other

PLEASE LIST NAME AND RELATIONSHIP OF ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION.
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Work Phone Confirmation
☐ Email Confirmation ☐ Any of the Above

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Work Phone Confirmation
☐ Email Confirmation ☐ Any of the Above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO on behalf of this Healthcare Facility via:

☐ Phone Message ☐ Text Message ☐ Email
☐ Any of the Above ☐ None of the above (opt out)

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In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because
- ☐ Other (please describe)

Response Date: _____