

A Notice to our Patients about our Privacy Policy and Information Practices

The Doctor(s) and Staff of Stones Family Dental are committed to maintaining the confidentiality of your personal, financial, and health information. State and Federal law requires us to inform you of our policy and practices as long as we provide you services.

How we protect your Personal Information:

We authorize individuals to access your personal information only to the extent necessary to conduct our business of serving you, such as making and confirming dental appointments, submitting insurance claims, securing insurance benefit information, and submitting applications for third party payment arrangements per your request. We take steps to secure our building, patient files, and electronic systems from unauthorized access. Our employees are trained regarding confidentiality and are held to strict Office Policy and Procedures regarding your personal and health information, both written and verbal. All employees are subject to discipline if they violate these procedures.

Information we collect:

Examples of your personal information include: your name, Social Security Number, address, telephone number, employment, medical history, health records, photographs, radiographs, claims information, and drivers license number.

Information we share:

We may share your personal or health information with other third parties with or without prior authorization **for our normal business functions**. Examples of our normal business functions include:

- Submission of Dental Claims
- Referrals to Specialists
- Request from other healthcare providers
- Request to or from pharmacies
- Processing transactions that you request
- Appointment notification via postcards, voice messages, or other written or verbal means.

Patient Rights:

We honor your right to request access to your personal information. To do so, you must submit a written request describing the information you are requesting. There will be a .25 per page or \$30.00 per hour charge for staff time to retrieve and copy the requested information plus postage. If we are able to locate and retrieve the information within 30 days from your request we will:

- Inform you of the nature and substance of the personal information either in writing or by telephone.
- Permit you to see and copy, in person, the requested information or to obtain a copy by mail, whichever you prefer.
- Disclose the persons to whom we've shared your personal information within the last six years, or if not available, the names of organizations or persons to whom the information is normally disclosed.
- Provide a summary of the procedures by which you may request correction, amendment or deletion of personal information.

If you request a correction, amendment or deletion of personal information, we will correct, amend or delete your personal information or we will notify you of our refusal. You may submit a statement telling us what you believe to be relevant or fair information and the reasons that you disagree with our decision. Your statements will be filed with your personal information.

Privacy Policy and Information Practices Patient Rights Statement
Use and Disclosure of Health Information Consent Form

Consent: By signing this form, you do consent to our use and disclosure of your personal health information to carry out treatment, payment activities and other healthcare operations required by this office. You acknowledge you are aware of our need to share your protected personal health information and have received your patient rights notification explaining in detail our office Privacy Policy and Information sharing Policy.

Right to revoke: You have the right to revoke this Consent at any time by giving us written notice. We will honor the request as of the day we receive your written notice. Please understand it will not affect any action taken before we received your revocation and we may decline to treat you or to continue treating you if you revoke this Consent.

Changes to Privacy Practices: We reserve the right to change our privacy practices described in our Patients Rights Privacy Policy and Information Practices. If we change our practices we will issue a revised Patients Rights Privacy Policy and Information Practice statement.

Patient Responsibility: We request timely notification of any changes to your personal information we maintain for you, such as but not limited to, health history information, address, telephone number, active insurance policy, and change in employer.

I, _____, have received a copy of the above named office's Privacy Policy and Information Practices for **the Doctor(s) and Staff of Stones Family Dental**. I have read and understand the above information. I understand that by signing this form I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

X _____
Signature Date Witnessed

Consenting Patient Information:

Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

Telephone: _____
Home Work Cell

Minor children also covered by this consent:

Name: _____	Date of Birth: _____
Name: _____	Date of Birth: _____
Name: _____	Date of Birth: _____
Name: _____	Date of Birth: _____