



## NOTICE OF PRIVACY PRACTICES (revised 9/20/2013)

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

### CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.  
(317)578-2224 kgwinn@advanced-endocare.com 8489 Fishers Centre Drive, Fishers, IN 46038

### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information ("medical information"). We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on the date set forth at the top of this page, and will remain in effect unless 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. We reserve the right to make any changes in our privacy practices and the new terms of our Notice applicable for all health information that we maintain, including health information we created or received before we made the change. We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you the revised notice. Any revised notice will be in effect for all health information that we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website if applicable. You may request a copy of our current notice at any time.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services, and information of importance to our patients. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our patients' health information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

### USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

**Treatment:** We may use or disclose your health information, without your prior approval, to another dentist, physician, or healthcare provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

**Payment:** We provide dental services. Your medical information may be used to seek payment from your insurance plan. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

**Healthcare Operations:** We may use and disclose your health information, with or without your prior approval, for healthcare operations. Healthcare operations include:

- quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, healthcare training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management, and general administration, including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for healthcare operations, public health activities, and research.

We may disclose your medical information to another dental or medical care provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has had a relationship with you and the medical information is for that provider's or plan's healthcare quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

**Your Authorization:** You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or revoke your written authorization at any time in writing, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your health information for any purpose other than those described in this notice. We will obtain your authorization prior to using your health information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of any of these communications.

**Family, Friends, and Others Involved in Your Care or Payment for Care:** We may disclose your health information to a family member, friend or other person you involve in your care or payment for your healthcare. We will disclose only the health information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your health information is in your best interest under the circumstances.

**Health-Related Products and Services:** We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services, and treatment alternatives.

**Appointment Reminders:** We may use or disclose your health information to provide you with reminders about your dental care, such as appointment reminders (sent via voicemail messages, postcards, or letters).

**Plan Sponsors:** If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

**Public Health and Benefit Activities:** We may use and disclose your health information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious or imminent threat to health and safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful processes;

- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state workers' compensation laws.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

**Business Associates:** We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

**Data Breach Notification Purpose:** We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.

**Additional Restrictions on Use and Disclosure:** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV / AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child and adult abuse or neglect, including sexual assault.

## **YOUR RIGHTS**

**Access:** You have the right to examine and to receive a copy of your health information, with limited exceptions. We will use the format you request unless we cannot feasibly do so. You should submit your request in writing to our Privacy Officer. We may charge you reasonable, cost-based fees for a copy of your health information, mailing the copy to you, and for preparing any summary or explanation of your health information you requested. Contact our Privacy Officer for information about our fees.

**Disclosure Accounting:** You have the right to receive a list of instances in which we disclosed your health information for purposes, other than treatment, payment, healthcare operations, as authorized by you, and for certain other activities.

You should submit your request by our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

**Amendment:** You have the right to request that we amend your health information. Your request must be in writing and submitted to our Privacy Officer. We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we deny your request, you may have a statement of your disagreement added to your health information. If we accept your request, we will make your amendment part of your health information and use reasonable efforts to inform others of the amendment who we know may have and rely on the amended information to your detriment, as well as persons you want to receive the amendment.

**Restriction:** You have the right to request that we restrict our use or disclosure of your health information for treatment, payment or health care operation, or with family, friends or others you identify. Except in limited circumstances, we are not required to agree to your request. But if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. Except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and
2. The medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

**Confidential Communication:** You have the right to request that we communicate with you about your health information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

**Breach Notification:** You have the right to receive notice of a breach of your unsecured health information. Breach may be delayed or not provided if so required by law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your health information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

**Electronic Notice:** If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form. Please contact our Privacy Officer to obtain this notice in written form.

## **QUESTIONS AND COMPLAINTS**

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, about amending your health information, or about how we communicate with you about your health information (including breach notice communication), you may contact our Privacy Officer.

You also may submit a written complaint to the Office for Civil Rights of the U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at (800)368-1019.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signed: \_\_\_\_\_ 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) \_\_\_\_\_

HEALTH INFORMATION RELEASE

We are unable to discuss your treatment with anyone unless you give us written permission.

I authorize the release of information including the diagnosis, records, images, examination rendered to me, and claims information. This information may be released to:

Please note: Certain treatments may require the patient be sedated. You will need to have a driver for such treatment. Your driver must be listed on this medical information release form prior to treatment.

My general and/or referring dentist Names: \_\_\_\_\_

Spouse Name: \_\_\_\_\_

Child(ren) Name(s): \_\_\_\_\_

Parent Name: \_\_\_\_\_

Other Name: \_\_\_\_\_

Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Messages

Please call my [ ] home [ ] work [ ] cell Number \_\_\_\_\_

If unable to reach me:

- You may leave a detailed message
Please leave a message asking me to return your call
Other \_\_\_\_\_

The best time to reach me is (day) \_\_\_\_\_ between (time) \_\_\_\_\_.