# STATEMENT OF PRIVACY PRACTICES

**Livingston Pediatric Dental Associates**
**315 East Northfield Road**
**Livingston, NJ 07039**
**973.992.5555**

## For informational purposes only
## This statement does not need to be printed

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 is effective as of September 20, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. 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 and to make the new notice provision effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

### Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Healthcare Insurance Portability and Accountability Act and the State of New Jersey. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone – even other family members – without your consent. You, of course, may give written authorization for Livingston Pediatric Dental Associates to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

### Collecting Protected Health Information (PHI)

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

### Disclosure Of Your Protected Health Information

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

**Treatment**: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment**: We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations**: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization**: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. 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 cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends**: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care**: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your child(ren) health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information thatis directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services**: We will not use your child(ren) health information for marketing communications without your written authorization.
**Required by Law**: We may use or disclose your child (ren) health information when we are required to do so by law.
**Abuse or Neglect**: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your child(ren) health of the safety and health of others.
**National Security**: We may disclose to the military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.
**Appointment Reminders**: We may use or disclose your health information to provide you with appointment reminders. Calls are made to home phone numbers and/or cell. Messages are left regarding dental appointments. Please let us know if you do not wish us to contact you in this manner.
**Incidental Disclosures:** We use an open bay in our office for most examinations. This environment provides positive behavior reinforcement (children seeing other children behaving well). Parts of dental treatment and/or conversations may be overheard by other patients or parents in the office. If you find that your child needs additional privacy, please request treatment in a private room. Be aware that scheduling for that room may be limited as we have limited private treatment operatories.
**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 practicably 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 and 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 you $0.50 for each page, $25.00 per hour for staff time to locate and copy
your health information, and postage if you want the copies mailed to you. If you request an alternative 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.)
**Disclosure Accounting**: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these requests.
**Restriction**: You have the right to request that we place additional restrictions on our use or disclosure 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 Communication**: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
**Amendment**: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
**Electronic Notice**: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.
**Breach Notification Rule (BNR) inclusion in the HITECH Act**: If a risk assessment demonstrates a probability of a breach of PHI, we are required to provide notification to affected individuals and to the Secretary of HHS following the discovery of such breach. Breaches of all data sets, regardless of content will be handled as a breach. If the breach is over 500 individuals, we must notify the media. Business associates will notify us within 60 days if they discover a breach.

## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to you health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information


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|---|---|
| Contact Officer: | Shari Summers, DMD |
| Telephone: | 973-992-5555 |
| Fax: | 973-992-1166 |
| E-Mail: | Livingstonpediatricdental@gmail.com |
| Address: | 315 East Northfield Road, Livingston, NJ 07039 |

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## Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for Livingston Pediatric Dental Associates. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of the office's health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also available in the facility.

Livingston Pediatric Dental Associates reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

_____ _____
Please print your child's name Please print your child's name

_____ _____
Please print your child's name Please print your child's name

_____ _____
Please print your child's name Please print your child's name

_____ _____
Legal Representative (sign here) Description of Authority (relationship to patient)

_____
Date

You may refuse to sign this acknowledgement and authorization, in refusing we may not be allowed to process your insurance claim. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of protected health information to the persons indicated below: this includes step parents, grandparents and any other care takers who can have access to this patient's records.

# Additional Disclosure Authority

| | | |
|---|---|---|
| **ANY MEMBER OF MY IMMEDIATE FAMILY** | **YES** | **NO** |
| **SPOUSE ONLY** | **YES** | **NO** |
| **OTHER (PLEASE SPECIFY)** | **YES** | **NO** |

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**I authorize contact from this office to confirm my child(ren) appointment, treatment and billing information via:**

◇ Cell Phone Confirmation
◇ Home Phone Confirmation
◇ Work Phone Confirmation
◇ Text Message to my Cell Phone
◇ Email Confirmation
◇ Any of the Above

**I authorize information about my child(ren) be conveyed via:**

◇ Cell Phone Confirmation
◇ Home Phone Confirmation
◇ Work Phone Confirmation
◇ Text Message to my Cell Phone
◇ Email Confirmation
◇ Any of the Above

**I approve being contacted about special services, events, fund raising efforts or new health information on behalf of Livingston Pediatric Dental Associates via:**

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

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**OFFICE USE ONLY BELOW THIS LINE**

**Record of Acknowledgement Not Obtained**

**Provided Prior to Treatment** **YES** **NO** **Date Provided:**

**Reason For Denial:**

- o **Needed more time to review Statement of Privacy Practices**
- o **Individual refused to sign**
- o **Communications barrier prohibited obtaining the acknowledgement**
- o **An emergency situation prevented us from obtaining acknowledgement**
- o **Wanted to consult with another person before signing**
- o **Reason not given**
- o **Other (Explain):**

**Copy of signed authorization provided to the individual:**
**Date:** _____ **Initials:** _____

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# To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Livingston Pediatric Dental Associates to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Livingston Pediatric Dental Associates health care operations. The patient information that may be emailed may include my x-rays, health history, and diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Livingston Pediatric Dental Associates may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- Livingston Pediatric Dental Associates does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Livingston Pediatric Dental Associates already sent before receiving my written instructions to stop.

Patient name (please print) _____

Signature: _____

Date: _____