SIGNATURE DENTAL EXPERIENCE NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by 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 takes effect September 23, 2013, and will remain in effect until we replace it.

We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. We will post a copy of our notice in our office. The effective date of the Notice is provided above.

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 the Privacy Officer whose contact information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may 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 another dentist or healthcare provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

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, and licensing or credentialing activities.

Appointments and Services. We may use your personal health information to remind you about appointments or to follow up on your visit.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Disaster relief: We may use or disclose your health information to assist in disaster relief efforts.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law.

Research: We may use and disclose your personal health information to researchers when their research has been approved by an institutional review board or privacy board and established protocols to ensure the privacy of your information.

Your Authorization: In specific situations, Signature Dental Experience will not use or disclose your PHI without you signing an authorization form. This form will describe what information will be disclosed, to whom, for what purpose, and when. You have the right to revoke this authorization in writing, except to the extent we have already relied upon it. These situations include: uses and disclosures of psychotherapy notes; uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; disclosures that constitute a sale of PHI; Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure.

Secretary of HHS: We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Health Oversight Activities.: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight agencies for activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Fundraising: We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive information from us you may opt out of receiving the communications.

Other Uses and Disclosures: We are permitted or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization.

Subject to conditions specified by law:

We may release your personal health information for any purpose required by law;

We may release your personal health information for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;

We may release your personal health information to certain governmental agencies if we suspect child abuse or neglect; we may also release your personal health information to certain governmental agencies if we believe you to be a victim of abuse, neglect, or domestic violence;

We may release your personal health information to entities regulated by the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;

We may release your personal health information to your employer when we have provided health care to you at the request of your employer for purposes related to occupational health and safety; in most cases you will receive notice that information is disclosed to your employer;

We may release your personal health information if required by law to a government oversight agency conducting audits, investigations, inspections and related oversight functions;

We may use or disclose your personal health information in emergency circumstances, such as to prevent a serious and imminent threat to a person or the public;

We may release your personal health information if required to do so by a court or administrative order, subpoena or discovery request; in most cases you will have notice of such release;

We may release your personal health information to law enforcement officials to identify or locate suspects, fugitives or witnesses, or victims of crime, or for other allowable law enforcement purposes;

We may release your personal health information to coroners, medical examiners, and/or funeral directors;

We may release your personal health information if necessary to arrange an organ or tissue donation from you or a transplant for you;

We may release your personal health information if you are a member of the military for activities set out by certain military command authorities as required by armed forces services; we may also release your personal health information if necessary for national security, intelligence, or protective services activities; and

We may release your personal health information if necessary for purposes related to your workers' compensation benefits.

RIGHTS THAT YOU HAVE

Access to Your Personal Health Information: Generally, you have the right to access, inspect, and/or receive paper and/or electronic copies of the personal health information that we maintain about you. Requests for access must be made in writing and be signed by you or your representative. We will charge you for a copy of your medical records in accordance with a schedule of fees established by applicable state law. You may obtain an access request form from Signature Dental Experience staff.

Amendments to Your Personal Health Information: You have the right to request that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. Please note that even if we accept your request, we may not delete any information already documented in your medical record. You may obtain an amendment request form from Signature Dental Experience staff.

Accounting for Disclosures of Your Personal Health Information: You have the right to receive an accounting of certain disclosures made by us of your personal health information except for disclosures made for purposes of treatment, payment, and healthcare operations or for certain other limited exceptions. This accounting will include only those disclosures made in the six years prior to the date on which the accounting is requested but, in no event will include disclosures made prior to April 13, 2003. Requests must be made in writing and signed by you or your representative. The first accounting in any 12-month period is free; you will be charged a fee of $20 for each subsequent accounting you request within a 12-month period.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request restrictions on certain of our uses and disclosures of your personal health information for treatment, payment, or health care operations. A restriction request form can be obtained from Signature Dental Experience. We are not required to agree to your restriction request, unless otherwise described in this notice, but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event we have terminated an agreed upon restriction, we will notify you of such termination.

Restrictions on Disclosures to Health Plans: You have the right to request a restriction on certain disclosures of your protected health information to your health plan. We are only required to honor such requests for restriction when you or someone on your behalf, other than your health plan, pay for the health care item(s) or service(s) in full. Such requests must be made in writing, and should identify the services that the restriction will apply to.
Please note that Signature Dental Experience is not required to inform and other providers of your request not to disclose PHI to a health plan, but will attempt to do so where feasible.

Confidential Communications: You have the right to request communications regarding your personal health information from us by alternative means or at alternative locations and we will accommodate reasonable requests by you. You must request such confidential communication in writing to each department to which you would like the request to apply.

Breach Notification: We are required to notify you in writing of any breach of your Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days after we discover the breach.

Paper Copy of Notice: As a patient you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.

ADDITIONAL INFORMATION

Complaints: If you believe your privacy rights have been violated, you may file a complaint in writing with Signature Dental Experience. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. All complaints must be made in writing and in no way will affect the quality of care you receive from us.

For further information: If you have questions or need further assistance regarding this Notice of Privacy Practices, you may contact us in writing at Signature Dental Experience Privacy Officer 109 N. Williamsburg Dr., Bloomington, IL 61701 email at bloomingtondentist@yahoo.com or phone at 309-662-3123.

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