



Fredericksburg Pediatric and Cosmetic Dentistry
4300 Plank Rd., Ste 230
Fredericksburg, VA 22407

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice describes how we may use and disclose your protected health information to provide treatment, obtain payment, and conduct health care operations and for other purposes permitted or required by law. Protected health information is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services. This notice will remain in effect until we replace it.

Uses and Disclosures

For each category of uses and disclosures, we explain what we mean and present some examples. Not every use or disclosure in a category is listed. However, all of the ways we are permitted to use and disclose information falls within one of the categories. When using or disclosing protected health information or when requesting protected health information from another covered entity, we make reasonable efforts to limit the protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.

Each time you visit, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information.

Treatment: We will use and disclose your health information to provide, coordinate and manage health care and related services for you. For example, we may disclose information to a specialist, physician, or healthcare provider providing treatment to you or to whom you have been referred to or from, and to ensure the provider has enough information to diagnose and/or treat you. We may also disclose information to your treating physician, who becomes involved in your care for the purpose of coordinating the different things you may need, such as prescriptions, x-rays, and dental treatment. We may also disclose information to a laboratory that, at our request, becomes involved in your treatment.

Payment: We will use and disclose your health information to obtain reimbursement for the treatment and services we provide to you. For example, we will send the necessary information to your health or dental insurance company to obtain payment for the treatment provided. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. We will also ask for payment at the time of checkout after services are rendered.

Healthcare Operations: We may use and disclose your health information to conduct the business activities of review of the performance and qualifications of employees, evaluating practitioner and provider performance, conducting training programs, legal services, audits, business planning (cost management), accreditation, certification, licensing or credentialing activities.

Incidental uses and disclosures: There are certain incidental uses or disclosures of your information that occur while we are providing service to you or conducting our business. For example, we will call you by name in the waiting room before bringing you back for your appointment. Also, after treatment, an assistant or dentist may need to use your name to identify family members that may be waiting for you in a waiting area. Other individuals waiting in the same area may hear your name called. We will make reasonable efforts to limit these incidental uses and disclosures.

Non-Medical Communications: Our practice may contact you for non-medical reasons. For example, we may send you a card, a holiday greeting or a thank you for referrals via mail or email to addresses on file.

Health Information Exchange

We participate in one or more electronic health information exchanges, which permits us to exchange health information about you with other participating providers. For example, we may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care, in order to have current information with which to treat you.

Treatment alternatives

We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders and other health information: We will call and confirm your or your child's appointment by leaving a message on an answering machine or with another member of your family prior to the appointment. We may also do this via emails, text messages, letters or postcards to the numbers and addresses you provide to us. We will not call or contact you or your designated guardian if you choose to fill out our printed contact form with specific instructions.

While you or your child are in our office, pictures are taken occasionally of your dentition and used for education issues, medical documentation, or for our office website.

Disaster Relief

We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family members or others involved in your health care.

To avert a serious threat to health or safety: In the event of your incapacity or in emergency circumstances, we may use or disclose your protected health information to treat you. Any disclosure, however, would only be to someone able to help prevent the threat. We will share your protected health information with business associates that perform specific functions for our practice such as billing, collections, software and dental labs. When a business arrangement of this type requires the use of your information, we will have a written contract with the third party to protect the privacy of your protected health information.

Individuals Involved in Your Health Care or Payment for your care: 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 or other person to the extent necessary to help with your health care, or with payment for your health care. We may also use or disclose health information to notify, or assist in the notification (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 we determine it is in your best interest based on our professional judgment or experience with common practices, we may allow another person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Your Authorization

In addition to our use of your health information listed above, 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 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. We do this if (a) you provide us written authorization to do so, or (b) you are unable to provide the required authorization because of emergency, accident or similar situation and we reasonably determine that disclosure would be in your best interest. In these situations, we may disclose protected health information necessary for your treatment or payment. We may use or disclose your name, location, and general condition, or assist in the identification, location or notification of a person involved in your care.

Required by law

We may use or disclose your health information when we are required to do so by law.

Special Situations

We may disclose health information about you when required or authorized by law to do so to the following types of entities, including but not limited to:

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation: We may provide your protected health information for worker's compensation or similar programs, which provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose protected health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- in connection with certain research activities; and
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court or administrative order. We may also disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

Law Enforcement: We may release protected health information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death regarding which we have been advised may be the result of criminal conduct;
- about criminal conduct on our premises; and

- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release protected health information to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release protected health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Minors: If you are an unemancipated minor under Virginia law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting in loco parentis, in accordance with our legal responsibilities.

Parents: If you are a parent of an unemancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care from us, we may disclose health information about your child to you. In some circumstances, we may not disclose health information about an unemancipated minor to you. For example, if your child is legally authorized to consent to treatment (without a separate consent from you), consents to such treatment, and does not request that you be treated as his or her personal representative, we may not disclose health information about your child to you without your child's written authorization.

Research

Under certain circumstances, we may disclose your health information for research consistent with our legal obligations, for example, when an institutional review board has reviewed the research proposal, established protocols to ensure the privacy of your health information, and approved the research.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. Health information includes treatment records, billing records and any other records used by us to make a decision about your treatment. You may obtain a form from our office to request access.

Disclosure: You have the right to receive a list of instances in which we or our business associates disclosed your health information. This list will not include certain disclosures, such as those made for treatment, payment, or health care operations and certain other types of disclosures, for example, as part of a facility directory or disclosures in accordance with your authorization. Your written request should indicate the 12 month time period you are requesting. If there is more than one request in any 12 month period, we may impose a reasonable, cost-based fee for any subsequent request.

Restriction: You have the right to request a restriction on the use and disclosure of your protected health information. You may also request that we not disclose some part of your information to family and others who may be involved in your care or for notification purposes as otherwise described in this Notice. We are not required to agree to the restrictions (especially if it impedes with our ability to provide you with the best standard of care), but if we do, we will abide by our agreement except in cases of emergency. You may request a restriction by sending your request in writing to our Privacy Contact.

Required by Law: We may use or disclose your health information when we are required to do so by federal, state, or local 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 health or safety or the health or safety of others.

Marketing: We will not use or disclose your protected health information for marketing purposes without your authorization.

Sale: we will not sell your protected health information to third parties without your authorization.

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.

Right to request confidential communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you only at work or only by mail. You must make your request in writing. We will accommodate reasonable requests.

If you want more information about our privacy practices or have questions, please contact us during normal business hours.

To file a complaint or to ask a question about this Notice, please send your request in writing to our Privacy Contact.

Changes to this Notice

We reserve the right to amend, change, or eliminate provisions in our privacy practices and to enact new provisions regarding the protected health information we maintain, including health information we created or received before we made the changes. If our information practices change, we will amend our Notice. You may request a revised printed copy of the Notice by visiting our office at any time.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under HIPAA, I have certain rights to privacy regarding my protected health information. By signing below, I acknowledge that I have received a copy of Fredericksburg Pediatric and Cosmetic Dentistry's Privacy Practices, and had an opportunity to review them.

Please print name _____ Birthdate _____

Signature _____

Date _____

If signed by Patient Representative, state authority to act on behalf of: _____
Patient Name

Relationship to patient: _____

Signature: _____ Printed Name: _____ Date: _____

OFFICE USE ONLY

Contact officer: Nicole Brandt

Telephone: (540) 785-5300

Address: 4300 Plank Rd. Ste 230 Fredericksburg, VA 22407

Patient Responsibilities and Financial Policy

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

Regarding Payment

- * Notify us of any changes in your address or insurance information at the time of the change.
- * Please fill out our registration, insurance and medical history forms completely and as thorough as possible. Unfortunately, we cannot see you without these being completed. Due to HIPAA Privacy Laws, we require your social security number and the subscriber's.
- * If you are more than 15 minutes late for an appointment, you may be asked to reschedule.
- * We accept the following forms of payment: Cash, Check, Visa and MasterCard.
- * Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing manager.
- * A \$50 charge may be billed to you for failing to keep your appointment and not providing at least 24 hour cancellation notice.
- * If dentures, partial dentures, crowns and bridges, or mouthguards are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.
- * The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist.
- * Checks that are returned to our office from your financial institution are subject to a \$50.00 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

- * Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed, however, it is also your responsibility to check with your insurance company to verify that we are a participating provider of your health plan prior to services.
- * All insurance co-pays and deductibles must be paid at the time of service.
- * If you do not have a valid insurance card (enrollment information will not be acceptable), you will be required to pay in full at the time of service. You will then be responsible for filing a claim with your insurance company for reimbursement, or you will have to reschedule your appointment.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I, _____ (print name) have read the Financial Policy. I understand and accept this Financial Policy.

Signature of Patient or Responsible Party: _____
Date: _____

Date: _____

I, _____, hereby authorize Fredericksburg Pediatric and Cosmetic Dentistry and/or their representatives to release any and all information pertaining to my health care, including test results, procedure, billing and / or accounting information to the following person(s), please circle:

- Myself
- Parents
- Other (please specify) _____

I further authorize the physicians and their representatives to contact me about appointments, results, payment and other information in one or more of the following ways (please circle):

- May call me
- May NOT call me
- Mail
- Text message
- At work
- At home
- Email _____

May leave messages at (please circle):

- At home
- At work
- Voicemail

I understand that if I wish to make changes to the status of this form, I will do so in writing.

Patient's signature

Date