

About Your Smile Dr. Bridget Doyle

1044 E. Lincoln Ave
Sapulpa, OK 74066
(918) 224-7000

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 IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.*

OUR LEGAL DUTY

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 takes effect 11/01/11, and will remain in effect until 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 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. 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.

USES AND DISCLOSURES OF 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 another dentist, physician or other health care 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 involved in your treatment to the extent necessary to help with your healthcare or with payment of 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 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 that is 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 health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your 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 health or safety or the health or safety of others.

National Security: We may disclose to 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 national security activities. We may disclose to correctional institution or law enforcement official 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 (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

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 \$0.25 for each page, \$15.00 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 the Notice for assistance in reaching the dentist or facility holding your health information.)

Disclosure Accounting: You may 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 November 01, 2011. 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 additional 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.

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 your 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. 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.

Contact: Office Manager

Telephone: (918) 224-7000

E-mail: aboutyourmile@gmail.com

Address: 1044 E. Lincoln Ave, Sapulpa, OK 74066-4505

**PATIENT CONSENT FOR TREATMENT AND USE AND
DISCLOSURE OF HEALTH INFORMATION**

SECTION A: PATIENT INFORMATION

Name: _____ DOB: ____/____/____
Address: _____ City/Zip: _____
Telephone: H: _____ C: _____ W: _____
Email: _____

SECTION B: YOUR INSURANCE INFORMATION *(Please provide a copy of your insurance card)*

Person Insurance is through: (Circle one) Self / Spouse / Parent

Name of Subscriber: _____ DOB: ____/____/____
Sex: M F Social Security # _____ - _____ - _____ Employer: _____
Name of Ins. Co: _____ Phone# _____
Individual # (if not Soc. Sec.#) _____ Group# _____

Do you have other dental insurance coverage (secondary)? Please provide that information

Name of Subscriber: _____ DOB: ____/____/____
Sex: M F Social Security # _____ - _____ - _____ Employer: _____
Name of Ins. Co: _____ Phone# _____
Individual # (if not Soc. Sec.#) _____ Group# _____

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGNATURE: _____ DATE: _____

SECTION C: INDIVIDUAL CONSENTING ON BEHALF OF PATIENT *(IF APPLICABLE)*

Name: _____ DOB: ____/____/____
Address: _____ City/Zip: _____
Telephone: H: _____ C: _____ W: _____
Email: _____ Relationship to Patient: _____

Continue on the back...

SECTION D: TO THE CONSENTING INDIVIDUAL – PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

Purpose of Consent: By signing this form, you consent to our use and disclosure of the protected health information of above-listed patient (hereinafter, "Patient") to carry out treatment, payment activates, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activates, and healthcare operations, of the uses and disclosures we may make of Patient's protected health information, and of other important matters about Patient's protected health information. A copy of our Notice accompanies this Consent. We encourage your to read it carefully and completely before signing the Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any Patient's protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting the office manager on the address of the front of the Notice.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Office Manager at the address on the front of this Notice. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat or to continue to treat Patient of your revoke this Consent.

I _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form. I am giving my consent to your use and disclosure of Patient's protected health information to carry our treatment, payment activities and health care options.

SIGNATURE: _____ **DATE:** _____

I revoke my Consent for your use and disclosure of Patient's protected health information for treatment, payment activities, and health care operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Sign below only if you reject (if selected: this option will not allow us to send claims and information to your insurance company and you will be responsible in sending your claims and full payment for services will be required on the day of service)

SIGNATURE: _____ **DATE:** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

SECTION E: AUTHORIZATION OF ADDITIONAL PERSON (S)

I authorize the following other person (s) personal representative (s) to make decisions about Patient's treatment on my behalf in my absence, and to receive protected health information about child in connection with treatment.

Personal representative's Name: _____ Relationship to Patient: _____
Telephone: H: _____ C: _____ W: _____

Personal representative's Name: _____ Relationship to Patient: _____
Telephone: H: _____ C: _____ W: _____

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Telephone: H: _____ C: _____ W: _____