Arcadia Dental
620 Old West Central Street
Suite #201
Franklin MA 02038
(508)541-7400

www.arcadiadental.info

NOTICE OF PRIVACY PRACTICES AT ARCADIA DENTAL

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY AS THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by state and federal law to maintain the privacy of your health information. We are also required to post this notice about our privacy practices, legal duties, and your rights with respect to your health information. We must follow the practices described herein as long as this notice is in effect. This notice went into effect August 2008 and will remain so until revised or replaced. Any questions about these practices, or for additional copies of this notice, please contact us according to the means listed below.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose your health information for treatment, healthcare operations and for payment.

For example:

Treatment: We may disclose your health information to a physician/dentist or other healthcare provider treating you

Healthcare Operations: We may use your health information in connection with our operations. This includes improvement and quality assessment activities, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

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

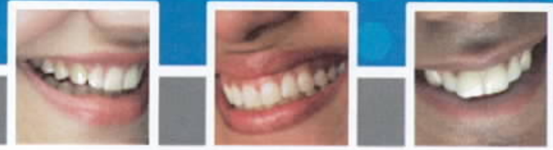
Your Authorization: In addition to the above, you may give us written authorization to disclose your health information to anyone for any purpose. This authorization may be revoked in writing at any time.

To Your Family and Friends: We must disclose your health information to you as described in the patients rights section of this notice. We may disclose your information to a family member, friend or other person, but ONLY IF YOU AGREE IN WRITING THAT WE MAY DO SO.

Persons Involved in Care: We may use or disclose you health information to notify (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, we will afford you an opportunity to object to such a use or disclosure. In the event of an emergency if you are incapacitated we will disclose health information using our professional judgment and disclose only information that is directly relevant to the persons involvement in your healthcare.

Marketing Health-Related Services: We will never use your health information for marketing communications without your written consent.

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 the appropriate authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence, or another crime. We may disclose your health information only to the extent needed to avert a serious threat to your health or safety or the health or safety of others. National Security: We may disclose to the Military Authorities the health information of Armed Forces personnel under certain circumstances. To authorized federal officials we may disclose health information required for lawful intelligence, counterintelligence, or other national security activities. We may also disclose information to a correctional institution or a law enforcement official that has lawful custody of inmate, under certain circumstances.

PATIENT RIGHTS

Access: You have the right to view and/or to receive copies of your health information, with few limitations. We will charge you a reasonable, cost-based fee for expenses such as materials and staff time.

Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your health information for purposes other than treatment, healthcare operations or payment for the last 6 years. If you request this accounting more than one time in any 12 month period, we will charge you a reasonable, cost-based fee for responding to the additional requests.

Restriction: You have the right to request additional restrictions on our use or disclosure of your health information. It is not required that we agree to the terms of the request, but if we do, we will abide by the agreement except in the case of 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. This request must be in writing and must specify the alternative means and/or location.

Amendment: You have the right to request that we amend your health information. This request must be in writing and explain why the information should be amended.

Electronic Notice: If you received this notice on our web-site, you are entitled to receive a copy of it in written form.

QUESTIONS AND CONCERNS

If you would like additional information about this policy or have any questions, please feel free to direct these questions to the Office Manager (who is also the HIPAA Compliance contact).

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or our handling of 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 an alternative location, please forward your concerns to the Office Manager: Danielle Vinson. You may also send written concerns to the US Department of Health and Human Services.

We support all of our patients rights to maintain the privacy of their health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

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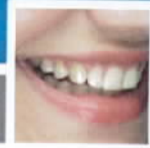

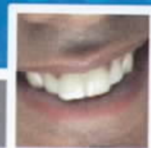

☐ I have read the Notice of Privacy Practices at Arcadia Dental, and grant the staff permission to share my medical information with agents and agencies involved in my care.

Signature of patient, parent, or guardian:

Signature: ______________________ Date: [ ]

Relationship to Patient:

[ ]

Response Date: [ ]