

# MAIN LINE CENTER FOR DENTAL EXCELLENCE

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## **HIPAA 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.**

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future dental condition and related health care services. This notice takes effect January 1, 2009 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 applicable law permits the changes. 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.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We may use and disclose your health information for different purposes, including treatment, payment and healthcare operations.

**Treatment:** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment:** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved in your care. 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. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations:** We may use and disclose your health information in connection to our healthcare operations. This includes, but are not limited to, quality assessment activities and employee review activities. We may also call you by name in our waiting room when your dentist or hygienist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

**To You and Your Family:** We may disclose your health information to a family member who is responsible to the extent necessary to help with your healthcare or with payment of your healthcare. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity, or an emergency, we will disclose your dental information based on our professional judgement or whether the disclosure would be in your best interest.

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

**Revoke This Authorization:** At any time, in writing, you may revoke this authorization, except to the extent that your dentist or dental practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## **YOUR RIGHTS**

**You have the right to inspect and copy your protected health information** with limited exceptions. You must make the request in writing. If you request information that we maintain on paper, we may provide photocopies. If you request information we maintain electronically, you have the right to an electronic copy.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**You have the right to request a restriction:** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends whom may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**If you have any questions or concerns, please contact us.**

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**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
For Office Use Only  
\_\_\_\_\_

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)