THIS NOTICE DESCRIBES HOW MEDICAL / DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it. All correspondence concerning any information on this form must be addressed to:

Boulevard Dental Associates, PA / Dr Edmund M Caruso DMD

2275 John F Kennedy Boulevard

Jersey City, NJ 07304

voice 201-434-3819 cell 201-424-5320 fax 201-434-3865

Email: FixMyTeeth2275@gmail.com

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you either in person, voice phone call, texting, or email; examining your teeth; prescribing medications and calling, email or faxing them to be filled; referring you to another doctor or clinic for other health care or services, and sending getting copies of your health information from another professional that you may have seen before us or need to see after us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment including credit / debit cards, other patient finance programs such as but not limited to CareCredit; preparing and sending bills or claims to insurance companies or to a guarantor of your account; and collection of unpaid amounts (either ourselves or through a collection agency or attorney).

"Health care operations" means those administrative and managerial functions that we have to do in order to run our office.

Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside physical or virtual storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

NAME: _____DATE:_____

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight, such as for the licensing of doctor; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or disclosures of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health-related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign services;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
  Disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information; unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care requesting information by phone, letter, email or text.

APPOINTMENT REMINDERS

We voice call, text, email or write you to remind you of scheduled appointments, or that it is time to make a routine or necessary appointment. We may also call, text, email or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will voice call, text, email or write you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosure for purposes of treatment (expect emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor

the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this notice.

- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know received the wrong information, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E-mail shown at the beginning of this notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of the notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you received one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this notice.

NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change of Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us first and then the U.S. Department of Health and Human Services, Office for Civil Rights.

We accept complaints to the office contact person at the address, fax or E-mail shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I read and/ or received a copy of the Notice of Privacy Practices which is always posted at our front desk and on our website for your inspection.

Full Name Patient/ Parent Guardian:

_____

Signature Patient/ Parent Guardian:

_____

Today's Date: _____

NAME: _____DATE:_____

HIPAA CONSENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical / dental services. Under HIPAA, unless you specifically object, we are allowed to use our professional judgement in deciding whether to discuss your medical / dental payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

_____You may communicate with the following individuals relating to my medical / dental INSURANCE for payment information:

_PLEASE PRINT YOUR INSURANCE NAME HERE_____

_____You may NOT communicate with the following individuals relating to my medical / dental or payment information:

_____

_____You may not communicate my medical / dental or payment information with anyone.

Full Name Patient/ Parent Guardian: _____

Signature Patient/ Parent Guardian: _____

Today's Date: _____

NAME: _____DATE:_____

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I _____ **DO** / _____ **DO NOT** authorize the professional office of my dentist named above to release health identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:
2. To whom may the information be released [name(s) or class(es) of recipients]:
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization is revoked.

Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[for marketing authorizations, include, as applications: We will receive or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING VOLUNTARILY.

I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Full Name Patient/ Parent Guardian: _____

Signature Patient/ Parent Guardian: _____

Today's Date: _____

NAME: _____DATE:_____