About You

Today's Date: _____

Name: _____

I prefer to be called: _____ Male Female

Birthdate: _____ Age: ____ SS #: _____

Home Address: _____

_____

Single Married Divorced Widowed Separated Minor

If minor, Parent name: _____

Hm #: _____ Cell #: _____

Wk #: _____ DL #: _____

Employer: _____

Employer's Address: _____

How long there?____ Occupation: _____

Where & when are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Last Visit Date: _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #: _____

Insured's Employer: _____

Spouse Information

His / Her Name: _____

Employer: _____

Wk #: _____ SS #: _____

Birthdate: _____ DL #: _____

Person Responsible for Account: _____

Wk #: _____ Hm #: _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

Medical History

Do you have a personal physician? Yes No

Physician's Name: _____

Phone: _____ Last Visit Date: _____

Are you currently under the care of a physician? Yes No

Please explain: _____

Is there someone who lives near to you who we should contact in the event of an emergency?

Name: _____ Relation: _____

Wk #: _____ Hm #: _____

Medical History (cont)

Your current physical health is: Good Fair Poor
Do you smoke or use tobacco in any form? Yes No
How Much? _____ How long? _____
Are you taking any prescription / over-the-counter or herbal supplement drugs? Yes No
Please list each one: _____

_____

Have you ever taken Fosamax or any other bisphosphonate? Yes No
Have you ever taken Phen-fen? Yes No
For Women: Are you using a prescribed method of birth control? Yes No
Are you pregnant? Yes No Week #: _____
Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

Y N	Abnormal Bleeding	Y N	Hepatitis
Y N	ADD/ADHD	Y N	Herpes / Fever Blisters
Y N	Alcohol / Drug Abuse	Y N	High Blood Pressure
Y N	Anemia	Y N	HIV+ / AIDS
Y N	Arthritis	Y N	Hospitalized for any reason
Y N	Artificial Bones / Joints / Valves	Y N	Kidney Problems
Y N	Asthma	Y N	Liver Disease
Y N	Blood Transfusion	Y N	Low Blood Pressure
Y N	Cancer / Chemotherapy	Y N	Lupus
Y N	Colitis	Y N	Mitral Valve Prolapse
Y N	Congenital Heart Disease	Y N	Mononucleosis
Y N	Diabetes	Y N	Pacemaker
Y N	Difficulty Breathing	Y N	Psychiatric Problems
Y N	Emphysema	Y N	Radiation Treatment
Y N	Epilepsy	Y N	Rheumatic / Scarlet Fever
Y N	Fainting Spells	Y N	Seizures
Y N	Frequent Headaches	Y N	Shingles
Y N	Glaucoma	Y N	Sickle Cell Disease
Y N	Handicaps / Disabilities	Y N	Sinus Problems
Y N	Hay Fever	Y N	Stroke
Y N	Heart Attack	Y N	Thyroid Problems
Y N	Heart Murmur	Y N	Tuberculosis (TB)
Y N	Heart Surgery	Y N	Ulcers
Y N	Hemophilia	Y N	Venereal Disease

Please list any medical conditions that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry / Metals	Y N	Sulfa
Y N	Dental Anesthetics	Y N	Latex	Y N	Tetracycline

Please list any other drugs / medications that you are allergic to:

Dental History

Why have you come to the dentist today?

_____

Has your physician told you that you require antibiotics prior to treatment? Yes No
Are you currently in pain? Yes No
Have you ever had a serious / difficult problem associated with any previous dental work? Yes No
Do you or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No
Your current dental health is: Good Fair Poor
Do you like your smile? Yes No
Have you considered bleaching your teeth? Yes No
Do your gums ever bleed? Yes No
How many times a day do you floss? _____
How many times a day do you brush? _____
Type of toothbrush? Hard Med Soft Electric

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature (Parent, if minor) Date

<u>Payment is due in full at time of treatment unless prior arrangements have been approved.</u>

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have a question at any time, please ask us. We are happy to help.

Our office is HIPAA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ **Date:** _____
Doctor's comments: _____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM
You may refuse to sign this acknowledgement but, in refusing we
will not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Joshua T. Smith, DDS. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

_____ _____
Please ***print*** your name Please ***sign*** your name

_____ _____
Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):
Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- □ Phone Confirmation
- □ Email Confirmation
- □ U. S. Mail / Postcard
- □ **Any of the above**

I AUTHORIZE **INFORMATION ABOUT MY DENTAL HEALTH** BE CONVEYED VIA:

- □ Phone Message
- □ Email Message
- □ U. S. Mail / Postcard
- □ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW DENTAL INFO** via:

- □ Phone Message
- □ Email
- □ U. S. Mail / Postcard
- □ **Any of the above**

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

_____
Signature of Privacy Officer

FINANCIAL POLICY

PAYMENT OPTIONS

CASH, CHECK, CREDIT CARDS (VISA, MC, AMER. EXPRESS AND DISCOVER)
PATIENT PAYMENT PLANS – NO INTEREST OR EXTENDED PAYMENT PLANS

PATIENT'S WITHOUT DENTAL INSURANCE

OUR OFFICE REQUIRES THAT PAYMENT BE DUE IN FULL AT THE TIME OF SERVICE.

PATIENT'S WITH DENTAL INSURANCE

1.) WE WILL FILE YOUR INSURANCE AS A COURTESY TO YOU, BUT YOUR ESTIMATED PAYMENT AND NECESSARY DEDUCTIBLE WILL BE DUE AT THE TIME OF SERVICE.
2.) THE ESTIMATED CO-PAYMENT IS MERELY AN ESTIMATE AND NOT A GUARANTEE OF PAYMENT BY YOUR INSURANCE COMPANY.
3.) CORRECT INSURANCE INFORMATION (NAME, ADDRESS AND PHONE NUMBER) MUST BE PROVIDED TO OUR OFFICE AT THE TIME OF SERVICE IN ORDER FOR US TO SUBMIT A CLAIM FORM. IF NOT PROVIDED, YOU WILL BE REQUIRED TO PAY FOR YOUR VISIT IN FULL AND HAVE YOUR INSURANCE COMPANY REINBURSE YOU.
4.) AFTER 60 DAYS ANY UNPAID BALANCE BECOMES YOUR RESPONSIBILITY AND IS SUBJECT TO FINANCE CHARGES AND TO THE COLLECTION PROCESS.

****THERE WILL BE A $25.00 CHARGE ON ALL RETURNED CHECKS. THERE WILL BE A $25.00 CHARGE FOR APPOINTMENTS THAT ARE MISSED OR CANCELLED WITHOUT GIVING 24 HOURS NOTICE****

SIGNIFICANT COSTS ARE INCURRED IN CARRYING OUT PATIENT ACCOUNTS. TO CONTROL THESE COSTS AND HELP KEEP FEES DOWN, IT IS NECESSARY TO ADHERE TO THIS FINANCIAL POLICY.

I AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR DENTAL SERVICES AND MATERIALS NOT PAID BY MY DENTAL BENEFIT PLAN. TO THE EXTENT PERMITTED UNDER APPLICABLE LAW, I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO MY DENTAL CARE. I HEREBY AUTHORIZE PAYMENT OF MY DENTAL BENEFITS TO SMITH FAMILY DENTISTRY.

_____ _____
PRINTED NAME OF PATIENT OR PATIENT'S GUARDIAN **DATE**

_____ _____
SIGNATURE OF PATIENT OR PATIENT'S GUARDIAN **DATE**

HIPAA NOTICE OF PRIVACY PRACTICES

for the Practice of:
Joshua T. Smith, DDS
801 E FM 1187 #B, Crowley, TX, 76036

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

For purposes of this Notice "us" "we" and "our" refers to Joshua T. Smith, DDS, and "you" or "your" refers to our patients (or their legal representatives as determined by us in accordance with state informed consent law). When you receive health-care services from us, we will obtain access to your medical information (i.e. your health history). We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so.

State law and the Health Insurance Portability & Accountability Act of 1996 (HIPAA) require us to maintain the confidentiality of all your health-care records and other individually identifiable health information used by or disclosed to us in any form, whether electronically, on paper, or orally ("PHI or Protected Health Information). HIPAA is a federal law that gives you significant new rights to understand and control how your health information is used. HIPAA and state law provide penalties for covered entities and records owners, respectively, that misuse or improperly disclose PHI.

Starting April 14, 2003, HIPAA requires us to provide you with the Notice of our legal duties and the privacy practices we are required to follow when you first come into our office for health-care services. If you have any questions about this Notice, please ask to speak to our privacy officer, (insert name) at (insert telephone number and extension, email address, etc.).

Our doctors, clinical staff, Business Associates (outside contractors we hire), employees and other office personnel follow the policies and procedures set forth in this Notice. If your primary doctor/ caretaker is unavailable to assist you (i.e. illness, on-call coverage, vacation, etc.), we may provide you with the name of another health-care provider outside our practice for you to consult with. If we do so, that provider will follow the policies and procedures set forth in this notice or those established for his or her practice, so long as they substantially conform to those for our practice.

OUR RULES ON HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Under the law, we must have your signature on a written, dated Consent form and/or an Authorization form (not an Acknowledgement form) before we will use and disclose your PHI for certain purposes as detailed in the rules below.

Documentation – You will be asked to sign a Consent / Authorization form when you receive this Notice of Privacy Practices. If you did not sign such a form or need a copy of the one you signed, please contact our Privacy Officer. You may take back or revoke your consent or authorization at any time (unless we already have acted based on it) by submitting our Revocation form in writing to us at our address listed above. Your revocation will take effect when we actually receive it. We cannot give it retroactive effect, so it will not affect any use or disclosure that occurred in our reliance on your Consent or Authorization prior to revocation (i.e. if after we provide services to you, you revoke your authorization or consent in order to prevent us billing or collecting for those services, your revocation will have no effect because we relied on your authorization or consent to provide services before you revoked it).

General Rule – If you do not sign our Consent form or if you revoke it, as a general rule (subject to exceptions described below under "Healthcare Treatment, Payment and Operations Rule" and "Special Rules"), we cannot in any manner use or disclose to anyone (excluding you, but including payers and Business Associates) your PHI or any other information in your medical record. By law, we are unable to submit claims to payers under

assignment of benefits without your signature on our Consent form. We will not condition treatment on your signing an Authorization, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the Consent or revoke it.

Health-care Treatment, Payment and Operations Rule

With your signed consent, we may use or disclose your PHI in order:

- To provide you with or coordinate health-care treatment and services. For example, we may review your health history form to form a diagnosis and treatment plan, consult with other doctors about your care, delegate tasks to ancillary staff, call in prescriptions to your pharmacy, disclose needed information to your family or others so they may assist you with home care, arrange appointments with other health-care providers, schedule lab work for you, etc.
- To bill or collect payment from you, an insurance company, a managed-care organization, a health benefits plan or another third party. For example, we may need to verify your insurance coverage, submit your PHI on claim forms in order to get reimbursed for our services, obtain pre-treatment estimates or prior authorizations from your health plan or provide your x-rays because your health plan requires them for payment; or
- To run our office, assess the quality of care our patients receive and provide you with customer service. For example, to improve efficiency and reduce costs associated with missed appointments, we may contact you by telephone, mail or otherwise remind you of scheduled appointments, we may leave messages with whomever answers your telephone or email to contact us (but we will not give out detailed PHI), we may call you by name from the waiting room, we may ask you to put your name on a sign-in sheet, we may tell you about or recommend health-related products and complementary or alternative treatments that may interest you, we may review your PHI to evaluate our staff's performance, or our privacy officer may review your records to assist you with complaints. If you prefer that we not contact you with appointment reminders or information about treatment alternatives or health-related products and services, please notify us in writing at our address listed above and we will not use or disclose your PHI for these purposes.

Special Rules

Notwithstanding anything else contained in this Notice, only in accordance with applicable law, and under strictly limited circumstances, we may use or disclose your PHI without your permission, consent or authorization for the following purposes:

- When required under federal, state or local law
- When necessary in emergencies to prevent a serious threat to your health and safety or the health and safety of other persons
- When necessary for public health reasons (i.e. prevention or control of disease, injury or disability, reporting information such as adverse reactions to anesthesia, ineffective or dangerous medications or products, suspected abuse, neglect or exploitation of children, disabled adults or the elderly, or domestic violence)
- For federal or state government health-care oversight activities (i.e. civil rights laws, fraud and abuse investigations, audits, investigations, inspections, licensure or permitting, government programs, etc.)
- For judicial and administrative proceedings and law enforcement purposes (i.e. in response to a warrant, subpoena or court order, by providing PHI to coroners, medical examiners and funeral directors to locate missing persons, identify deceased persons or determine cause of death)
- For workers' compensation purposes (i.e. we may disclose your PHI if you have claimed health benefits for a work-related injury or illness)
- For intelligence, counterintelligence or other national security purposes (i.e. Veterans Affairs, U.S. military command, other government authorities or foreign military authorities may require us to release PHI about you)
- For organ and tissue donation (i.e. if you are an organ donor, we may release your PHI to organizations that handle organ, eye or tissue procurement, donation and transplantation)
- For research projects approved by an Institutional Review Board or a privacy board to ensure confidentiality (i.e. if the researcher will have access to your PHI because involved in your clinical care, we will ask you to sign an authorization)

- To create a collection of information that is "de-identified" (i.e. it does not personally identify you by name, distinguishing marks or otherwise and no longer can be connected to you)
- To family members, friends and others, but only if you verbally give permission. We give you an opportunity to object and if you do not, we reasonably assume, based on our professional judgment and the surrounding circumstances, that you do not object (i.e. you bring someone with you into the operatory or exam room during treatment or into the conference area when we are discussing your PHI); we reasonably infer that it is in your best interest (i.e. to allow someone to pick up your records because they knew you were our patient and you asked them in writing with your signature to do so); or it is an emergency situation involving you or another person (i.e. your minor child or ward) and, respectively, you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because, after a reasonable attempt, we have been unable to locate you. In these emergency situations we may, based on our professional judgment and the surrounding circumstances, determine that disclosure is in the best interests of you or the other person, in which case we will disclose PHI, but only as it pertains to the care being provided and we will notify you of the disclosure as soon as possible after the care is completed.

Minimum Necessary Rule

Our staff will not use or access your PHI unless it is necessary to do their jobs (i.e. doctors uninvolved in your care will not access your PHI; ancillary clinical staff caring for you will not access your billing information; billing staff will not access your PHI except as needed to complete the claim form for the latest visit; janitorial staff will not access your PHI). Also, we disclose to others outside our staff only as much of your PHI as is necessary to accomplish the recipient's lawful purposes. For example, we may use and disclose the entire contents of your medical record:

- To you (and your legal representatives as stated above) and anyone else you list on a Consent or Authorization to receive a copy of your records
- To health-care providers for treatment purposes (i.e. making diagnosis and treatment decisions or agreeing with prior recommendations in the medical record)
- To the U.S. Department of Health and Human Services (i.e. in connection with a HIPAA complaint)
- To others as required under federal or state law
- To our privacy officer and others as necessary to resolve your complaint or accomplish your request under HIPAA (i.e. clerks who copy records need access to your entire medical record)

In accordance with the law, we presume that requests for disclosure of PHI from another Covered Entity (as defined in HIPAA) are for the minimum necessary amount of PHI to accomplish the requestor's purpose. Our Privacy Officer will individually review unusual or non-recurring requests for PHI to determine the minimum necessary amount of PHI and disclose only that. For non-routine requests or disclosures, the Plan's Privacy Officer will make a minimum necessary determination based on, but not limited to, the following factors:

- The amount of information being disclosed
- The number of individuals or entities to whom the information is being disclosed
- The importance of the use or disclosure
- The likelihood of further disclosure
- Whether the same result could be achieved with de-identified information
- The technology available to protect confidentiality of the information
- The cost to implement administrative, technical and security procedures to protect confidentiality

If we believe that a request from others for disclosure of your entire medical record is unnecessary, we will ask the requestor to document why this is needed, retain that documentation and make it available to you upon request.

Incidental Disclosure Rule

We will take reasonable administrative, technical and security safeguards to ensure the privacy of your PHI when we use or disclose it (i.e. we require employees to talk softly when discussing PHI with you, we use computer passwords and change them periodically (i.e. when an employee leaves us), we allow access to areas where PHI is stored or filed only when we are present to supervise and prevent unauthorized access.

Business Associate Rule

Business Associates and other third parties (if any) that receive your PHI from us will be prohibited from re-disclosing it unless required to do so by law or you give prior express written consent to the re-disclosure. Nothing in our Business Associate agreement will allow our Business Associate to violate this re-disclosure prohibition.

Super-confidential Information Rule

If we have PHI about you regarding HIV testing, alcohol or substance abuse diagnosis and treatment, or psychotherapy and mental health records (super-confidential information under the law), we will not disclose it under the General or Health-care Treatment, Payment and Operations Rules (see above) without your first signing and properly completing our Consent form (i.e. you specifically must initial the type of super-confidential information we are allowed to disclose). If you do not specifically authorize disclosure by initialing the super-confidential information, we will not disclose it unless authorized under the Special Rules (see above) (i.e. we are required by law to disclose it). If we disclose super-confidential information (either because you have initialed the consent form or the Special Rules authorize us to do so), we will comply with state and federal law that requires us to warn the recipient in writing that re-disclosure is prohibited.

Changes to Privacy Policies Rule

We reserve the right to change our privacy practices (by changing the terms of this Notice) at any time as authorized by law. The changes will be effective immediately upon us making them. They will apply to all PHI we create or receive in the future, as well as to all PHI created or received by us in the past (i.e. to PHI about you that we had before the changes took effect). If we make changes, we will post the changed Notice, along with its effective date, in our office. Also, upon request, you will be given a copy of our current Notice.

Authorization Rule

We will not use or disclose your PHI for any purpose or to any person other than as stated in the rules above without your signature on a specifically worded, written Authorization form (not a Consent or an Acknowledgement). If we need your Authorization, we must obtain it a specific Authorization form, which may be separate from any Consent or Acknowledgement we may have obtained from you. We will not condition treatment on whether you sign the Authorization (or not).

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

If you got this Notice via email or website, you have the right to get, at any time, a paper copy by asking our privacy officer. Also, you have the following additional rights regarding PHI we maintain about you:

To Inspect and Copy

You have the right to see and get a copy of your PHI including, but not limited to, medical and billing records by submitting a written request to our privacy officer on our Request to Inspect, Copy, or Summarize form. Original records will not leave the premises, will be available for inspection only during our regular business hours, and only if our privacy officer is present at all times. You may ask us to give you the copies in a format other than photocopies (and we will do so unless we determine that it is impracticable) or ask us to prepare a summary in lieu of the copies. We may charge you a fee not to exceed state law to recover our costs (including postage, supplies, and staff time as applicable, but excluding staff time for search and retrieval) to duplicate or summarize your PHI. We will not condition release of the copies or summary on payment of your outstanding balance for professional services (if you have one), but we may condition release of the copies or summary on payment of the copying fees. We will respond to requests in a timely manner, without delay for legal review, in less than thirty days if submitted in writing on our form or otherwise, and in ten business days or less if malpractice litigation or pre-suit production is involved. We may deny your request in certain limited circumstances (i.e. we do not have the PHI, it came from a confidential source, etc). If we deny your request, you may ask for a review of that

decision. If required by law, we will select a licensed health-care professional (other than the person who denied your request initially) to review the denial and we will follow his or her decision. If we select a licensed health-care professional who is not affiliated with us, we will ensure a Business Associate agreement is executed that prevents re-disclosure of your PHI without your consent by the outside professional.

To Request Amendment / Correction

If another doctor involved in your care tells us in writing to change your PHI, we will do so as expeditiously as possible upon receipt of the changes and will send you written confirmation that we have made the changes. If you think PHI we have about you is incorrect, or that something important is missing from your records, you may ask us to amend or correct it (so long as we have it) by submitting a Request for Amendment / Correction form to our Privacy Officer. We normally will act on your request within 60 days from receipt, but we may extend our response time (within the 60-day period) no more than once and by no more than 30 days, in which case we will notify you in writing why and when we will be able to respond. If we grant your request, we will let you know within five business days, make the changes by noting (not deleting) what is incorrect or incomplete and adding to it the changed language, and send the changes within 5 business days to persons you ask us to and persons we know may rely on incorrect or incomplete PHI to your detriment (or already have). We may deny your request under certain circumstances (i.e. it is not in writing, it does not give a reason why you want the change, we did not create the PHI you want changed (and the entity that did can be contacted), it was compiled for use in litigation, or we determine it is accurate and complete). If we deny your request, we will (in writing within 5 business days) tell you why and how to file a complaint with us if you disagree, that you may submit a written disagreement with our denial (and we may submit a written rebuttal and give you a copy of it), that you may ask us to disclose your initial request and our denial when we make future disclosure of PHI pertaining to your request, and that you may complain to us and the U.S. Department of Health and Human Services.

To an Accounting of Disclosures

You may ask us for a list of those who got your PHI from us by submitting a Request for Accounting of Disclosures form to us. The list will not cover some disclosures (i.e. PHI given to you, given to your legal representative, given to others for treatment, payment or health-care-operations purposes). Your request must state in what form you want the list (i.e. paper or electronically) and the time period you want us to cover, which may be up to but not more than the last six years (excluding dates before April 14, 2003). If you ask us for this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee to respond, in which case we will tell you the cost before we incur it and let you choose if you want to withdraw or modify your request to avoid the cost.

To Request Restrictions

You may ask us to limit how your PHI is used and disclosed (i.e. in addition to our rules as set forth in this Notice) by submitting a written Request for Restrictions on Use, Disclosure form to us (i.e. you may not want us to disclose your surgery to family members or friends involved in paying for our services or providing your home care). If we agree to these additional limitations, we will follow them except in an emergency where we will not have time to check for limitations. Also, in some circumstances we may be unable to grant your request (i.e. we are required by law to use or disclose your PHI in a manner that you want restricted, you signed an Authorization form, which you may revoke, that allows us to use or disclose your PHI in the manner you want restricted; in an emergency).

To Request Alternative Communications

You may ask us to communicate with you in a different way or at a different place by submitting a written Request for Alternative Communication form to us. We will not ask you why and we will accommodate all reasonable requests (which may include: to send appointment reminders in closed envelopes rather than by postcards, to send your PHI to a post office box instead of your home address, to communicate with you at a telephone number other than your home number). You must tell us the alternative means or location you want us to use and explain to our satisfaction how payment to us will be made if we communicate with you as you request.

To Complain or Get More Information

We will follow our rules as set forth in this Notice. If you want more information or if you believe your privacy rights have been violated (i.e. you disagree with a decision of ours about inspection / copying, amendment / correction, accounting of disclosures, restrictions or alternative communications), we want to make it right. We never will penalize you for filing a complaint. To do so, please file a formal, written complaint within 180 days with:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201
877.696.6775

Or, submit a written Complaint form to us at the following address:

Our Privacy Officer:	*Jamie Johnson*
Office Name:	*Joshua T. Smith, DDS*
Office Address:	*801 E FM 1187 #B*
	Crowley, TX, 76036
Office Phone:	*817-297-0200*
Office Fax:	*817-297-6200*

You may get your complaint form by calling our privacy officer.

These privacy practices will be effective April 14, 2003, and will remain in effect until we replace them as specified above.

OPTIONAL RULES FOR NOPP

Faxing and Emailing Rule

When you request us to fax or email your PHI as an alternative communication and we agree to do so, we may fax or email super-confidential information; we will not use fax or email for emergency communication without knowing that the recipient is expecting the message; have only our privacy officer or treating doctor fax or email your PHI; have our privacy officer confirm that the fax number or email address is correct before sending the message and ensure that the intended recipient has sole acce3ss to the fax machine or computer before sending the message; confirm receipt, locate our fax machine or computer in a secure location so unauthorized access and viewing is prevented; use a fax cover sheet so the PHI is not the first page to print out (because unauthorized persons may view the top page); and attach an appropriate notice to the message.

Practice Transition Rule

If we sell our practice, our patient records (including but not limited to your PHI) may be disclosed and physical custody may be transferred to the purchasing doctor, but only in accordance with the law. The doctor who is the new records owner will be solely responsible for ensuring privacy of your PHI after the transfer and you agree that we will have no responsibility for (or duty associated with) transferred records. If all the owners of our practice die, our patient records (including but not limited to your PHI) must be transferred to another doctor within 90 days to comply with Board of Dentistry Rules 64B5-17.001(1) and (2) Admin code. Before we transfer records in either of these two situations, our privacy officer will obtain a Business Associate agreement from the purchaser and review your PHI for super-confidential information (i.e. HIV/AIDS records), which will not be transferred without your express written authorization (indicated by your initials on our Consent form).

Inactive Patient Records

We will retain your records for seven years from your last treatment or examination, at which point you will become an inactive patient in our practice and we may destroy your records at that time (but records of inactive minor patients will not be destroyed before the child's eighth birthday). We will do so only in accordance with the law (i.e. in a confidential manner, with a Business Associate agreement prohibiting re-disclosure if necessary).

Collections and Marketing

If we use or disclose your PHI for marketing (i.e. communications that encourage recipients to purchase or use a product or service) or collections purposes, we will do so only in accordance with the law.