

## NOTICE OF PRIVACY PRACTICES

DingusOrthodontics, P.C.  
110 High Street  
Newark, NY 14513

### 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.*

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for the following purposes: treatment, payment, and health care operations.

\***Treatment** means providing, coordinating or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.

\***Payment** means such activities obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

\***Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- \*Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- \*Obtain payment from third-party payers.
- \*Conduct normal health care operations such as quality assessments and physician certificates.

I have received, read and understood your *Notice of Privacy Practices* containing a more complete description of the use and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to so as documented below.

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_