Croasdaile
DENTAL ARTS
Your Smile. Our Passion.

CHILD MEDICAL HISTORY FORM pg1

SELECT YOUR DENTIST: **DATE: _____**
____ Dr. Will Turner **____ Dr. Jason Butler** **____ Dr. Melissa Owen**

PATIENT INFORMATION: ___Married ___Single
Name _____ ___Male ___Female
(LAST) (FIRST) (MIDDLE INITIAL) DOB _____
Address: _____, State _____ Zip _____
What name would you like to be called in this office? _____
Whom may we thank for referring you?_____
School/College: _____ City _____ State _____ _ __Full Time ___Part Time

FAMILY INFORMATION:

MOTHER
Name: _____
Address:_____
City _____ State _____ Zip _____
Home# _____Work_____Ext___
Cell # _____ Pager _____
Email: _____
Birthdate: _____ SSN#:_____
Employer/Occupation: _____

FATHER
Name: _____
Address:_____
City_____ State _____ Zip _____
Home# _____Work_____Ext___
Cell # _____ Pager _____
Email: _____
Birthdate: _____ SSN#:_____
Employer/Occupation: _____

Please name two people to contact outside of immediate family in case of emergency: (not living with you)
Name: _____ Home# _____ Work#_____
Address: _____ City: _____ State: _____ Zip: _____

Name: _____ Home# _____ Work#_____
Address: _____ City: _____ State: _____ Zip: _____

FINANCIAL INFORMATION: (note: please review our Financial Policy form)
Please check the person financially responsible for the account
____ Patient ____ Father ___ Mother ____Guardian ____Spouse ___Other (specify) _____

Does responsible party have an account with this office ____Yes ____ No
Method of Payment: ____ Check _____ Cash ____ Mastercard/Visa
Where appropriate and necessary, credit bureau reports will be obtained.

Dental Insurance 1
Employee Name: _____
Employer Name: _____
Insurance Co. Name: _____
Insurance Co. Address:_____
_____
Subscriber I.D. #: _____
Group #: _____
Employee Date of Birth: _____

Dental Insurance 2
Employee Name: _____
Employer Name: _____
Insurance Co. Name: _____
Insurance Co. Address:_____
_____
Subscriber I.D. #: _____
Group #: _____
Employee Date of Birth: _____

Authorization: I hereby authorize payment directly to Drs. Turner & Butler, DMD, PA and the associate dentist, of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

Responsible Party Signature: _____ **Date: _____**
State Driver's License #: _____

Please complete the following page regarding Medical History

CHILD MEDICAL HISTORY FORM pg2

Patient Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ___ Yes ___ No If yes, please explain _____
Have you ever been hospitalized or had a major operation? ___ Yes ___ No If yes, please explain _____
Have you ever had a serious head or neck injury? ___ Yes ___ No If yes, please explain _____
Are you taking any medications? (Rx, OTC, Supplements) ___ Yes ___ No If yes, please list all here _____
_____
_____
_____

Do you take, or have you taken, Phen-Fen or Redux? ____Yes ___ No If yes, please explain _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ____Yes ___ No If yes, please explain _____
Are you on a special diet? ____Yes ___ No If yes, please explain _____
Do you use tobacco? ____Yes ___ No
Do you use controlled substances? ____Yes ___ No
Do you have sleep apnea? ____Yes ___No
Do you use a C-PAP machine? ____Yes ___No
Do you use Electronic cigarette? ____Yes ___No

Women are you
____ Pregnant or Trying to get pregnant?
_____Nursing?
_____Taking oral contraceptives

Are you allergic to any of the following?
____ Aspirin ____Penicillin ____Codeine ____ Acrylic ____Metal____ Latex ____Sulfa Drugs ____ Local Anesthetics
____ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

____ AIDS/HIV Positive	____ Chest Pains	___Genital Herpes	___ Kidney Problems	___ Rheumatism
____ Alzheimer's Disease	____ Cold Sores/Fever Blisters	___Glaucoma	___ Leukemia	___ Scarlet Fever
____ Anaphylaxis	____ Congenital Heart Disorder	___Hay Fever	___ Liver Disease	___ Shingles
____ Anemia	____ Convulsions	___Heart Attack/Failure	___ Low Blood Pressure	___ Sickle Cell Disease
____ Angina	____ Cortisone Medication	___Heart Murmur	___ Lung Disease	___ Sinus Trouble
____ Arthritis/Gout	____ Diabetes	___Heart Pace Maker	___ Mitral Valve Prolapse	___ Spina Bifida
____Artificial Heart Valve	_____ Drug/Alcohol Addiction	___Heart Trouble/Disease	___ Organ Transplant	___ Stomach/Intestinal
____ Artificial Joint	_____ Easily Winded	___ Hemophilia	___ Osteoporosis	___ Stroke
____ Asthmas	_____ Emphysema	___ Hepatitis A	___ Pain in Joints	___ Swelling of Limbs
____ Blood Clot/DVT	_____ Epilepsy or Seizures	___ Hepatitis B or C	___ Parathyroid Disease	___ Thyroid Disease
____ Blood Disease	_____ Excessive Bleeding	___ Herpes	___ Psychiatric Care	___ Tonsillitis
____ Blood Transfusion	_____ Excessive Thirst	___ High Blood Pressure	___ Radiation Treatment	___ Tuberculosis
____ Breathing Problems	_____ Fainting Spells/Dizziness	___ High Cholesterol	___ Recent Weight Loss	___ Tumors or Growths
____ Bruise Easily	_____ Frequent Cough	___ Hives or Rash	___ Renal Dialysis	___ Ulcers
____ Cancer	_____ Frequent Diarrhea	___ Hypoglycemia	___ Rheumatic Fever	___ Venereal Disease
____ Chemotherapy	_____ Frequent Headaches	___ Irregular Heartbeat		

Have you ever had any serious illness not listed above? ____ Yes ____ No If yes, please explain: _____
_____

Comments:_
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

I understand that Croasdaile Dental Arts (Drs. Turner & Butler, DMD, PA) and their associate dentist requires that a new Medical History Form be completed once a year.

Signature of Patient, Parent or Guardian _____ Date: _____

Revised 11/2018

Croasdaile
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Adult New Patient
Dental History Questionnaire

Patient Name: _____ **DOB: _____**

What would you like to accomplish today? _____
What prompted you to seek dental care at this time? _____
Have you been asked to take an antibiotic before dental treatment? ☐Yes ☐ No

Please check if you have ever had problems with any of the following:
☐Sensitivity to cold ☐Jaw/ear pain ☐Bleeding Gums ☐Food sticks between teeth
☐Sensitivity to hot ☐Grinding/clenching teeth ☐Periodontal treatment ☐Mouth sores/growths
☐Sensitivity when biting ☐Clicking or popping jaw ☐Loose teeth/broken fillings ☐Bad Breath/Taste
☐Sensitivity to sweets ☐Worn/chipped teeth ☐Dark teeth ☐Hard to floss

Home Care Evaluation
How often do you brush?_____ Toothbrush: ☐ Electric ☐ Regular ☐ Soft ☐ Medium ☐ Hard
How often do you floss?_____ Any other homecare devices that you use? _____
Is it difficult for you to brush or floss any areas of your mouth? ☐ Yes ☐ No
If yes, please describe: _____

Do your gums bleed when brushing or flossing?	☐ Yes ☐ No
Do you have dry mouth?	☐ Yes ☐ No
Do you want to learn to control dental disease & keep your teeth?	☐ Yes ☐ No
Have you ever been instructed in the prevention of decay?	☐ Yes ☐ No
Have you been instructed in caring for the health or your gums?	☐ Yes ☐ No
Do you feel like keeping your teeth healthy has been a losing battle?	☐ Yes ☐ No

If yes, why? _____

Do you have any concerns about getting your mouth in excellent health?	☐ Yes ☐ No

If yes, what concerns you?_____

Do you snack between meals on sweets, gum or soda pop?	☐ Yes ☐ No
Do you chew on both sides of your mouth?	☐ Yes ☐ No ☐ Unsure

Smile Evaluation
What do you like about your smile? _____
What don't you like about your smile? _____

Do you sometimes hesitate to smile?	☐ Yes ☐ No
Are your teeth white enough?	☐ Yes ☐ No
Are there old fillings or dental work that look bad to you?	☐ Yes ☐ No
Do you like the shape of your teeth?	☐ Yes ☐ No
Are your teeth straight enough?	☐ Yes ☐ No
Do you have spaces between your teeth that you don't like?	☐ Yes ☐ No
Has cost prevented you from enhancing your smile in the past?	☐ Yes ☐ No

Other History

Are you anxious about receiving dental treatment?	☐ Yes ☐ No

If yes, what do you dislike? _____

Has fear of discomfort kept you from regular dental visits in the past?	☐ Yes ☐ No

What else would you like us to know about your past dental experiences?
_____

Have you ever had a reaction to a dental product or procedure?	☐ Yes ☐ No

If yes, please describe: _____
Previous Dentist: _____ Address _____ City _____, State _____
Date of Last visit: _____ Date of Last X-rays: _____

SIGNATURE:_____ **DATE:_____**
CDA-DH revised 7/27/17

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Missed Appointment Policy

We will make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments. If you are unable to do so, please notify us at least 24 hours in advance. When you provide us with 24 hours' notice we are able to accommodate other patients in need of treatment.

Please read our policy as indicated below:

Cancellations are requested with 24 hours notice, otherwise it is concerned a missed appointment.

- **First missed appointment –** We realize patients get sick, people sometimes forget, or another emergency arises. As soon as you are aware that you can't make the appointment, call us – even late at night you are able to leave a message on our answering machine. Typically, we don't charge for the first missed appointment; however, we do reserve the right to do so.

- **Second missed appointment** – A missed appointment fee of $50.00 will be charged to your account. This will be charged per family member if multiple appointments scheduled and broken. Please note: Insurance will **not** pay for this charge. We require that the missed appointment fee be paid in full before scheduling another appointment.

- **Third missed appointment** - You will be charged another $50.00 missed appointment fee. In addition, we also reserve the right to dismiss you from our practice.

Note: Parents bringing in two or more family members at the same time will be restricted from scheduling a double or triple appointment after missing two such appointments for multiple family members.

Thank you for your courtesy.

(Note: Prior to implementation the policy and notification process have been approved and met the requirements of the North Carolina Dental Society and was also reviewed by our attorney.)
Updated 07/27/17

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy 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 healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your ***NOTICE OF PRIVACY PRACTICES*** containing a more complete description of the uses 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 my 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 acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: ____ Reason: _____

Revised 05/27/17

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name _____ **Date of Birth** _____

Croasdaile Dental Arts is authorized to release protected health information about the above named patient to the entities name below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you Approve to receive information	**Description of information to be released.** Check each that can be given to person/ entity on the left in the same section.
____ VOICE MAIL/ANSWERING MACHINE	____ Results of lab tests/x-rays ____ Appointments, follow-up calls or insurance
____ EMAIL Email address_____ ____TEXT APPTS to # _____	____ Financial ____ Correspondences: Recall cards, newsletters, announcements, etc. ____ Appointments, follow-up calls or insurance.
____ SPOUSE (provide full name) _____	____ Financial ____ Appointments, follow-up calls or insurance.
____ PARENT (provide names) _____	____ Financial ____ Appointments, follow-up calls or insurance.
____ OTHER (provide names) _____	____ Financial ____ Appointments, follow-up calls or, insurance.

Patient Information

I understand that I have the right to revoke this information at anytime and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse or sign this authorization and that my treatment will be conditioned on signing. **This authorization shall be in effect until revoked by patient.**

_____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority: _____

Revised 5/27/17

Drs. Turner & Butler, DMD, PA
Dba: CROASDAILE DENTAL ARTS
2900 Croadaile Dr, Ste 5
Durham, NC 27705
919-383-7402 office

FINANCIAL POLICY

Our primary goal is not to allow the cost of treatment to prevent your benefiting from the quality care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance affordable.

Our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment.

Payments

We accept the following forms of payment: CASH, CHECK, VISA, MASTER CARD, AMERICAN EXPRESS and DISCOVER. For your convenience, you may pay account balances electronically through www.patientpaycenter.com and use the office statement code: YDV1H9. In addition, we offer CARE CREDIT and SPRINGSTONE, a patient payment program offering a full range of No Interest and Extended Payment Plans for treatment fees.

Payment is expected at the time of your services. If you have dental insurance, we will provide an estimate of your co-payment and collect your portion at the time of your appointment. If an overpayment is made, you will receive a refund once all claims are processed.

You will receive a statement for balance due within 30 days, as well as, balance due after insurance letter. If you do not please contact the billing office 919-383-7402.

A finance charge of 1.5% will be assessed monthly to account balance after 60 days.

Any unpaid balance over 90 days will be considered delinquent and turned over to a collection agency. Fees may apply. Once accounts are turned over to the collection agency you will be dismissed from the practice. The responsible party of the account will receive notification via certified mail. You have 30 days from receipt of notification to find a new dentist.

Return check fee is $25. We have the right to seek appropriate relief from the court of proper jurisdiction for full payment plus all costs, treble damages, and witness fees in accordance to North Carolina law, if payment has not been received within 30 days of notification

A credit report is required for all financial arrangements made within the practice

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment to your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our staff at any time to discuss any concerns you may have.

Dental Insurance

It's important to remember that your insurance coverage is a contract between your employer and your insurance company. Benefits and coverage vary significantly from plan to plan depending upon what your employer has agreed to with the insurer. Please keep in mind that insurance is not designed to provide 100% benefit, but rather is meant to ***assist*** in the cost of dental care. To avoid surprises on your bill, it is important to understand what your insurance will cover, and what you will need to cover in some other way. Dental benefits should not be confused with the dental services you need. We do not participate in any dental insurance networks.

As a courtesy to our patients, we are happy to submit your claims for services. In order for us to do this, you must provide us with accurate and up-to-date insurance information. We will confirm your coverage and plan and we will estimate the insurance portion and your co-payment. This may or may not be what the insurance company will actually pay. Your plan may base its dollar allowance on a usual and customary fee schedule which may not coincide with current fees in our area. We'll do our best to help you receive maximum benefits. Patients are responsible for all balances incurred for services received.

If you are unable to present a valid member identification card from your carrier at your visit, we will expect payment in full until you are able to verify your insurance coverage.

We will wait 60 days for insurance claims to be paid. After 60 days if payment has not been made, you will be asked to pay the balance and seek reimbursement from your insurance company.

Divorce Parents:

In the case of a divorce, regardless of decree, the parent authorizing treatment for child(ren) will be the parent responsible for those subsequent charges. We are unable to bill separate parties; therefore it is the parent's responsibility to work out these details of payments.

Patient under the age of 26

Please plan to be present at appointments with your child under 18. If you cannot be there, please make prior arrangements with our staff. The parent accompanying a minor child is responsible for payment. If your child is over 18 and you will not be accompanying him/her to the appointment, please send payment along with your child or call with a card number to run while they are here.

Missed Appointment

Our practice is dedicated to quality care and exceptional service. Our doctors and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as for other patients. If you find that you must change your appointment, we require a minimum of 48 hour notice, so that we can make every effort to accommodate other patients. If proper notice is not received, we reserve the right to charge a missed appointment fee of $50 for every hour of allotted time that was cancelled. . The 3rd missed appointment could result in being dismissed from the practice.

Waiver of Confidentiality: You understand if we submit your account to an attorney or collection agency, if we have to litigate in court, or your past due status is reported to a credit report agency, the fact that you received treatment at our office may become a matter of public record.

Charges for Phone Calls: If a dentist is called, either after hours or during weekends or holidays, for prescriptions or refills a charge of $25.00 may be assessed. Charge is waived if the patient is seen in the office.

Acknowledgement

I have read this Patient Financial Policy as outlined, and understand that I am ultimately responsible for the charges incurred by me or by child(ren) as their legal parent or guardian.

This is an agreement between Drs. Turner & Butler, DMD, PA as creditor, the Patient/Guardian, or Parent as debtor, named on this form.

By executing this agreement, you are agreeing to pay for all services that are received.

Patient/Guardian Signature_____ Date: _____

Patient/Guardian Printed Name _____

FP 05 23 2017

Drs. Turner & Butler, DMD, PA
DBA: Croasdaile Dental Arts
2900 Croasdaile Drive, Suite 5
Durham, NC 27705
919-383-7402 office

Medicare Private Contract

This contractual agreement is between Drs. Turner & Butler, DMD, PA and _____("Patient"). As dentist who have **OPTED-OUT** of Medicare on September 1, 2004 (effective date) Drs. Turner, Butler and their associate, Dr. Cole have informed Patient or his/her legal representative that treatment they provide to any Medicare beneficiary is not subject to Medicare limits.

As required by law, this agreement clearly states that Drs. Turner & Butler, DMD, PA are providers in good standing with the Medicare program under Section 1128, 1156 or 1892 of the Social Security Act.

By signing this contract the patient or his/her legal representative agrees with the following:

A. Patient or his/her legal representative accepts full responsibility for payment of the Dentist's charge for all services furnished by Dentist.

B. Patient or his/her legal representative understands that Medicare limits do not apply to what the Dentist may charge for services.

C. Patient or his/her legal representative understands that they **cannot submit a claim** to Medicare, Medicare Advantage or Medicare Replacement policies.

D. Patient or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare covered items and services from physicians and practitioners who have not opted-out of Medicare.

E. Patient or his/her legal representative understands that medigap or supplemental plans may elect not to make payments for services not filed or paid for by Medicare.

This contract shall remain in force from date signed by the patient or his/her legal representative until the Dentist informs patient that the OPT-OUT period has been cancelled.

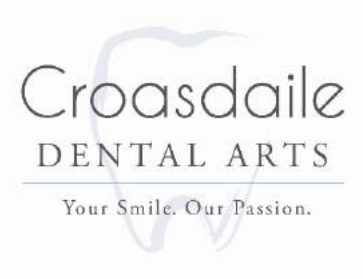
Dentist Signature:_____

Patient/Legal Representative:_____

Relationship to Patient:_____

DATE:_____

Revised 05 23 17



Dental Insurance Facts

Fact 1 — **NO INSURANCE PAYS 100% OF ALL PROCEDURES**

If your insurance stated they will pay 100% of a procedure. It is based on the insurance company's fee list (called an UCR list) and not the individual dentist's fee list.

Example: A procedure cost is $180.00, your insurance policy states they will pay 100% of what they allow. If they allow $150.00 the remaining $30.00 is the parent's balance.

Fact 2 — INSURANCE BENEFITS ARE NOT DETERMINED BY OUR OFFICE

Your insurance benefit is determined by the type of plan selected by your employer. We have no input on what your insurance pays for procedures. Insurance companies set their own fee schedules, and each insurance company has a different set of fees and guidelines.

Fact 3 — Deductible

When estimating your dental insurance, benefits make sure to consider your deductible. Each insurance company has a different deductible amount. You have to meet your deductible amount before most insurance companies will pay for any treatment.

Revised 7/25/17

Drs. Turner & Butler, DMD, PA
Dba Croasdaile Dental Arts
2900 Croasaile Drive, Ste
Durham, NC 27705

Notice of Privacy Practices

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.

If you have any questions about this Notice please contact the Privacy Officer.
Kim Dodson or Christi Bintliff

Effective Date: April 14, 2003 **Revised: April 11, 2013**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **www.croasdailedentalarts.com**

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- <u>If required by law:</u> The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- <u>Public health activities:</u> The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- <u>Health oversight agencies:</u> We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- <u>Legal proceedings:</u> To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- <u>Police or other law enforcement purposes</u>: The release of PHI will meet all applicable legal requirements for release.

- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

<u>All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.</u>

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

<u>Your Privacy Rights</u>

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation, we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Kim Dodson, HIPAA Compliance Officer 919-383-7402

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint, we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 13, 2003