NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on January 1st 2016 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer,Vanessa Y. Garza-Flores. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $.25for each page and the staff time charged will be $5.00per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)

We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $.25for each page and the staff time charged will be $ 5.00 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: Compassion Dental of Harlingen Privacy Officer: Vanessa Y. Garza-Flores

Telephone: 956-428-4434 Fax: 956-428-4431

Email: Compassiondentalofharlingen@gmail.com

Address:2401 Ed Carey Drive Suite B. Harlingen, Texas 78550

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Printed Name of Patient | Legal Relationship to the Patient (If required)

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name_____ Relationship_____ Phone_____
2. Name_____ Relationship_____ Phone_____

Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please initial_____.

The email address that I authorize to receive email messages for appointment reminders and general health information is_____. Please initial_____.

OR

_____ I **decline** to receive communications via **text.**

_____ I **decline** to receive communications via **email.**

Revocation – Use this area to document revocation of a previous form of communication.

__I hereby revoke my request to receive future appointment reminders or healthcare updates via text.

__I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature_____ Date requested:_____

Reminder – Keep information to the minimum necessary and encrypt emails and texts whenever possible.

HIPAA Acknowledgement of receipt of the Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state, law.

AUTHORIZATION AND CONSENT

Consent to Treatment

I agree and consent to a dental examination by Dr. Guillen. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me proper to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Personal Health Information

I authorize Dr. Guillen to release any information regarding my dental/medical history, diagnosis or treatment to third party payers and/or other healthy professionals.

Electronic Communication Consent

Email communication provides for a fast and easy way to communicate with your healthcare team for those issues that are non-emergent, non-urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the patient-healthcare provider/team relationship: rather it can support and strengthen an already established relationship. In case you are referred to a dental specialist practice for treatment, your x-rays may need to be transmitted by unsecured email, such as AOL/Yahoo, which are not encrypted. If this is not agreeable to you, please let us know.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Guillen.

Photography Release

I authorize Dr. Guillen to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options.

I understand and agree to the **Consent to Treatment**
I authorize the **Release of Personal Health Information**
I authorize the **Release of X-rays through email**
I understand and will comply with the **Financial Policy.**
I authorize Photographs to be taken of me and shown to other **patients.**
I acknowledge that I have read the **Privacy Notice** of this practice.
I have been given the opportunity to ask any questions concerning any information above.

Patient/Guardian Signature_____ **Date** _____

Office Appointment Policy

WE VALUE YOUR TIME:

We don't schedule anyone else at your time.
You are seen on time, and you will not be waiting with a room full or patients.

IN RETURN:

Please show up for your appointment on time. Our patients appreciate being seen on time and giving them OUR best. Your help in keeping our schedule running smooth is really appreciated. THANKS!

If unable to keep your appointment, please give up a 24-hour notice. If you do not, this is considered a "Broken Appointment" and leaves us without a patient: therefore, billing must occur. A MINIMUM of $50 will be charged to your account.

I have read and understood this appointment policy. I have had the opportunity to ask any questions. I understand I will pay for any **"Broken Appointments".**

Patient Signature _____ Date _____
Staff Member Signature _____

Compassion Dental of Harlingen

"We Are Compassion"

Patient Registration

Dr. Ricardo Guillen
Welcomes You

We need certain information about you to make treatment as safe and successful as possible. Please read and fill out both sides carefully. If you have any questions, be sure they are answered before signing this form.

Date _____

Name _____ _____ _____ _____ _____ _____ _____
Last First Married Single Child Other Male Female

Home # _____ Cell # _____

Address _____ Apt# _____ City _____ State _____ Zip _____

Soc. Sec. # _____ Birth Date _____ Driver's Lic. # _____

Email Address _____

Dental Insurance

Yes ____ No ____ (circle one)

BCBS of TX MetLife Aetna Humana Delta Dental Cigna
Guardian Ameritas Lincoln Principal Assurant Other

Policy Holder Name _____ Birth Date _____

Social Security Number _____ Group Number/Member ID _____

Whom may we thank for referring you? _____

Or did you come in because of ____ Our website ____ Social media ____ Google ____Street sign

Financial Policy

Payment of your treatment is due in full the day services are rendered. Should you have dental insurance with assignment to Dr. Guillen, the estimated patient portion will be the amount due. Insurance payments without assignment will be sent to the insured with payment due in full the day of service. For your convenience we **accept Cash, Check, Visa, MasterCard and Discover**. We also offer short and long-term financing options, (interest free options may apply) **Returned checks are subject to a 45.00 NSF fee**. Dental Insurance plans often pay less than the actual fee for services, therefore the patient or guarantor is the responsible party for all services provided. Dental insurance is a benefit with limitations and should not be expected to take care of all costs. Your insurance benefits will be explained during your consultation appointment.

OFFICE USE ONLY

Pt Name:

DOB:

MEDICAL HISTORY INFORMATION

Have you ever had any of the following:

__ AIDS/HIV positive
__Anemia
__Arthritis
__Artificial Joints
__ Artificial Heart Valve
__Asthma
__Breathing Problems
__Blood Disease
__Cancer
__Chemical Dependency
__Chemotherapy/Radiation
__Cholesterol
__Dementia/Alzheimer's
__Diabetes
__Dizziness or Fainting
__Epilepsy or Seizures
__Excessive Bleeding
__Glaucoma
__Head Injuries
__Heart Disorders (congenital)
__Heart Infection
__Heart Murmur
__Heart Pace Maker/Stent
__Heart Surgery
__Hepatitis
__High Blood Pressure
__Kidney Problems
__Liver Problems
__Mental Disorders
__Mitral Valve Prolapse
__Nervous Disorders
__Osteoporosis
__Pregnant: Due Date _____
__Respiratory Problems
__Rheumatism
__Sinus Problems
__Sleep Apnea
__Stomach Problems
__Stroke
__Surgical Shunt
__Thyroid Problems
__Tuberculosis
__Tumors
__Ulcers
__Venereal Disease
__Yellow Jaundice

__Other:

Have you ever had any cosmetic surgery? __Yes __No
Have you ever taken the diet drug Phen-Phen? __Yes __No
Are you on a blood thinner of any kind? __Yes __No
Do you take an omega 3 or fish oil? __Yes __No
Do you take any herbals? __Yes __No If yes, what? _____
Do you take or have you taken: Bisphosphonates
i.e. Fosamax, Aredia, Actonal, Zometa, Boniva or any other? __Yes __No If yes, how long taken? _____

Are you allergic to __ aspirin __ penicillin __ sulfa __ codeine __ iodine __ metal __ latex

Do you have any health problems that need further clarification? If yes, explain _____

_____

Are you under the care of a physician? If yes, explain _____

Physician Name _____ Phone _____

Have you been admitted to a hospital or needed emergency care during the past two years? If yes, explain

_____

Have you ever had complications with any dental treatment? If yes, explain _____

_____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications change, without fail, I will inform the dentist and the staff at my next appointment.

Signature of Patient/Guardian _____ **Date** _____

OFFICE USE ONLY

I have read MEDICAL HISTORY and confirm that it states past and present conditions.

Date _____ **Signature of Dentist/Hygienist** _____

OFFICE USE ONLY
Pt Name:
DOB:

Medications

I have an **allergy** to the below medications and/or other allergies:

1._____ 4._____

2._____ 5._____

3._____ 6._____

This is a **current** list of all medication I am taking:

	Medication	**Dosage/Times per day**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		

Reviewed by: _____ **Date:** _____

New Patient Evaluation

Name:

Please circle Yes or No

Are you a Smoker/Tobacco user? YES or NO

If yes, about how much a day: _____

Do you consume Alcohol? YES or NO

How Often: _____

Do you take any Daily Supplements/Vitamins? YES or NO

Please List: _____

Do you experience any headaches due to grinding/clinching of the teeth? YES or NO

Any allergies to Latex? YES or NO

Experience any reaction to Anesthetic? YES or NO

If yes, due to what Anesthetic and what type of reaction occurred?

_____

Oral Care Self-Evaluation

Do you experience any sensitivity to Hot or Cold? YES or NO

Any bleeding of gums due to brushing and/or flossing? YES or NO

Are you happy with the appearance of your teeth, shape and color? YES or NO

Would you be interested in teeth whitening? _____

How would you rate your smile? 1 2 3 4 5 6 7 8 9 10

Poor Satisfied Excellent

Are there any other concerns with your teeth that we should know about?

_____