HEATHER L. M. BREUER, D.M.D.
GENERAL FAMILY DENTISTRY

DEAR PROSPECTIVE PATIENT,

DR. BREUER AND HER STAFF WELCOME YOU TO OUR PRACTICE. WE BELIEVE IN PROVIDING THE FINEST QUALITY DENTAL CARE IN A FRIENDLY, UPBEAT ENVIRONMENT. WE MAKE DENTISTRY FUN!

WE HAVE ENCLOSED OUR NEW PATIENT PACKET, PLEASE BRING THE COMPLETED FORMS WITH YOU AT THE TIME OF YOUR INITIAL APPOINTMENT.

PLEASE READ OVER OUR **NOTICE OF PRIVACY PRACTICES,** AND **OFFICE POLICIES**.

WE ASK THAT YOU REMEMBER TO BRING THE FOLLOWING ITEMS TO YOUR INITIAL APPOINTMENT:

_____ COMPLETED MEDICAL HISTORY FORM
_____ COMPLETED PATIENT REGISTRATION FORM
_____ CURRENT INSURANCE CARD (S) OR CLAIM FORM COMPLETE WITH POLICYHOLDERS DATE OF BIRTH (DOB) AND SS#.

WE KNOW YOUR DENTAL HEALTH IS IMPORTANT, AND WE APPRECIATE YOUR CHOOSING OUR OFFICE TO CARE FOR YOUR DENTAL NEEDS.

WE ENJOY OUR WORK, AND LOOK FORWARD TO MEETING YOU.

SINCERELY,

HEATHER L. M. BREUER AND
STAFF

HEATHER L. M. BREUER, D.M.D.
GENERAL FAMILY DENTISTRY

PATIENT REGISTRATION FORM

____ PRIVACY NOTICE

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES FROM BREUER DENTAL.

_____IN LIEU OF THE PATIENT SIGNATURE, I_____,
A STAFF MEMBER OF BREUER DENTAL, STATE THAT THIS PATIENT HAS BEEN GIVEN OUR CURRENT NOTICE OF PRIVACY PRACTICES.

_____ AUTHORIZATION TO DISCUSS MY ACCOUNT

IT IS THE POLICY OF THIS PRACTICE TO CALL OUR PATIENTS TO RESCHEDULE APPOINTMENTS IF NECESSARY, TO CONFIRM APPOINTMENTS FOR A FUTURE DATE, AND TO INFORM YOU OF TEST RESULTS. WHEN WE WILL CALL YOU, WE MAY LEAVE A MESSAGE ON YOUR ANSWERING MACHINE OR SPEAK WITH WHOMEVER ANSWERS THE PHONE. YOUR INITIALS ON THE SECTION INDICATE THAT THIS IS ACCEPTABE TO YOU. IF THIS IS NOT ACCEPTABLE, PLEASE LET US KNOW UPON REGISTRATION SO THAT WE CAN NOTE THIS IN OUR COMPUTER.

____ CONSENT TO TREAT:

I HEREBY AUTHORIZE AND CONSENT TO THE PERFORMANCE OF EXAMINATIONS, DIAGNOSTIC PROCEDURES AND TREATMENTS WHICH DR. BREUER AND I AGREE ARE NECESSARY. I UNDERSTAND THAT NO GUARANTEE HAS BEEN MADE AS TO THE RESULTS OF THE CARE, TREATMENT, AND /OR MEDICATIONS GIVEN TO ME. THIS CONSENT SHALL REMAIN IN EFFECT UNTIL I CHOOSE TO REVOKE IT IN WRITING.

____ RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY FEES FOR SERVICES RENDERED FOR MYSELF AND /OR FOR MY CHILDREN (IF APPLICABLE). I HEREBY AUTHORIZE BREUER DENTAL TO FURNISH INFORMATION TO MY INSURANCE CARRIER CONCERNING ALL CONDITIONS DENTAL RELATED. I HEREBY ASSIGN TO BREUER DENTAL PAYMENTS MADE BY MY INSURANCE CARRIER.

____ PATIENT FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT BREUER DENTAL WILL, AS A COURTESY TO ME, SUBMIT THE CHARGES FOR MY VISIT TO MY PRIMARY AND ASSIST ME IN FILING WITH SECONDARY INSURANCES CARRIERS. IF THERE IS ANY QUESTION REGARDING COVERAGE, BENEFITS, OR PAYMENT FOR SERVICES PROVIDED, I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO RESOLVE THIS, I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY COVERED OR NON-COVERED SERVICES WHICH ARE NOT PAID BY MY PRIMARY OR SECONDARY INSURANCE AND THAT ANY UNPAID CHARGES OVER 60 DAYS OLD WILL BECOME MY RESPONSIBILITY, WITH PAYMENT DUE FROM ME PLUS PROCESSING COSTS. IN THE EVENT MY ACCOUNT IS PLACED WITH AN AGENCY FOR COLLECTION PURPOSES, I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COLLECTION AGENCY FEES (50% OF THE BALANCE) PLACED FOR COLLECTION. IN ADDITION, I WILL BE RESPONSIBLE FOR ALL COURT COSTS, FILING FEES, AND ATTORNEY FEES SOULD THIS ACCOUT REQUIRE LITIGAITON.

MY SIGNATURE BELOW INDICATES MY KNOWLEDGE OF AND AGREEMENT WITH ALL OF THE ABOVE:

_____

(SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE) (PRINTED NAME) (DATE)

_____

(IF SIGNED ABOVE BY REPRESENTATIVE, RELATIONSHIP OF SIGNER TO PATIENT) (NAME OF PATIENT IF DIFFERENT FROM ABOVE)

PATIENT INFORMATION

CONFIDENTIAL

DATE _____

(PLEASE PRINT)

NAME _____ (FIRST MI LAST) BIRTHDATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SOC. SEC. NO. _____ CELL PHONE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE/PROV. _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

_____ BIRTHDATE _____ _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____		
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
6. ARE YOU WEARING CONTACT LENSES?	☐	☐

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	LOCAL ANESTHETICS (EG. NOVOCAINE)	☐	☐	BARBITURATES	☐	☐	ASPIRIN
☐	☐	PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	SEDATIVES	☐	☐	OTHER _____
☐	☐	SULFA DRUGS	☐	☐	IODINE			_____

8. WOMEN ONLY:

	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

9. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	HEART DISEASE	☐	☐	CHEST PAINS
☐	☐	HEART ATTACK	☐	☐	CARDIAC PACEMAKER	☐	☐	EASILY WINDED
☐	☐	RHEUMATIC FEVER	☐	☐	HEART MURMUR	☐	☐	STROKE
☐	☐	SWOLLEN ANKLES	☐	☐	ANGINA	☐	☐	HAY FEVER / ALLERGIES
☐	☐	FAINTING / SEIZURES	☐	☐	FREQUENTLY TIRED	☐	☐	TUBERCULOSIS
☐	☐	ASTHMA	☐	☐	ANEMIA	☐	☐	RADIATION THERAPY
☐	☐	LOW BLOOD PRESSURE	☐	☐	EMPHYSEMA	☐	☐	GLAUCOMA
☐	☐	EPILEPSY / CONVULSIONS	☐	☐	CANCER	☐	☐	RECENT WEIGHT LOSS
☐	☐	LEUKEMIA	☐	☐	ARTHRITIS	☐	☐	LIVER DISEASE
☐	☐	DIABETES	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐	HEART TROUBLE
☐	☐	KIDNEY DISEASES	☐	☐	HEPATITIS / JAUNDICE	☐	☐	RESPIRATORY PROBLEMS
☐	☐	AIDS OR HIV INFECTION	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	OTHER _____
☐	☐	THYROID PROBLEM	☐	☐	STOMACH TROUBLES / ULCERS			_____

COMMENTS

_____

_____

_____

_____

_____

_____

SIGNATURE OF DENTIST DATE

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A) CLICKING?	☐	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D) DIFFICULTY IN CHEWING?	☐	☐
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor)

Doctor's Comments _____

_____

_____ *Signature* _____ *Date* _____

HEATHER L. M. BREUER, D. M. D.
GENERAL FAMILY DENTISTRY

OFFICE POLICIES

DEAR PATIENTS,

SINCE THE FOUNDING OF OUR PRACTICE, WE HAVE ALWAYS OFFERED THE BEST DENTAL CARE POSSIBLE. IN ORDER TO CONTINUE TO DO SO, WE WANT TO EXPLAIN TO YOU OUR PAYEMNT POLICY.

IN OUR PRACTICE, WE EXPECT A PAYMENT AT THE TIME OF SERVICE FOR PATIENTS WHO HAVE NO INSURANCE COVERAGE. FOR THOSE PATIENTS WHO HAVE COVERAGE, WE OFFER THE COURTESY OF SUBMITTING CHARGES TO INSURANCE, AND WE EXPECT THAT ANY PATIENT DUE PORTION WILL BE PAID IN A TIMELY MANNER. AS A COURTESY TO YOU, WE WILL ASSIST YOU IN FILING YOUR SECONDARY PLANS.

IF YOUR VISIT INVOLVES WORKER'S COMPENSATION, WE MUST HAVE WRITTEN DOCUMENTION FROM YOUR EMPLOYER VERIFYING THE WORKER'S COMPENSATION STATUS, ALONG WITH SPECIFIC INFORMATON REGARDING THE INJURY AND INSURANCE COVERAGE. WITHOUT THIS DOCUMENTATION, WE WILL BILL YOUR DENTAL INSURANCE PLAN. IF YOU HAVE NO DENTAL INSURANCE WE REQUIRE A PREPAYMENT OF $100.00.

IF YOUR VISIT INVOLVES LIABILITY INSURANCE COVERAGE, WE MUST HAVE WRITTEN DOCUMENTATION FROM YOU WITH ALL THE NECESSARY INFORMATION. WITHOUT THIS DOCUMENTATION, WE WILL BILL YOUR DENTAL INSURANCE PLAN. IF YOU HAVE NO DENTAL INSURANCE, WE REQUIRE A PREPAYMENT OF $100.00.

WE SEND MONTHLY STATEMENTS TO INFORM YOU OF ANY BALANCES DUE, AND WE WILL ALSO REMIND YOU OF MONEY DUE WHEN YOU CALL TO SCHEDULE AN APPOINTMENT AND WHEN WE CALL TO CONFIRM APPOINTMENTS. WE EXPECT THAT PATIENT DUE BALANCES WILL BE PAID UPON RECEIPT OF OUR STATEMENT, OR AT YOUR NEXT VISIT. IF IT BECOMES NECESSARY TO PLACE YOUR ACCOUNT WITH A COLLECTION AGENCY, ALL COSTS OF THIS PROCESS WILL BE YOUR RESPONSIBILITY.

WHILE OUR BILLING PROFESSIONALS WILL DO ALL THEY CAN TO HELP YOU IN COMMUNICATING AND NEGOTIATING WITH YOUR INSURACE PLAN, WE MUST INFORM YOU THAT ANY BALANCE REMAINING ON YOUR ACCOUNT THAT IS 60 DAYS OLD WILL BE CONSIDERED YOUR RESPONSITILITY AND BILLED TO YOU.

WE KNOW YOUR TIME IS IMPORTANT AND FROM TIME TO TIME, YOU WILL NEED TO CANCEL AND RESCHEDULE YOUR APPOINTMENT. WE ASK THAT YOU GIVE US 24-HOUR NOTICE. OUR ANSWERING MACHINE IS ON 24 HOURS A DAY. IN THE CASE OF A LAST MINUTE APPOINTMENT CONFLICT, PLEASE PHONE AS SOON AS YOU ARE ABLE.

NO SHOWS OR FAILED APPOINTMENTS TAKE AWAY TIME THAT WE MIGHT OFFER OUR OTHER PATIENTS. A CHARGE OF 20.00 PER ½ HOUR APPOINTMENT WILL BE CHARGED TO YOUR ACCOUNT, AND ALL FUTURE DATES CURRENTLY IN OUR APPOINTMENT BOOK WILL BE CANCELLED. THE FAILED APPOINTMENT CHARGES (S) MUST BE PAID PRIOR TO ANY RE-APPOINTMENTS.

PLEASE BE AWARE THAT IF THE DEKALB COUNTY SCHOOL DISTRICT CLOSES SCHOOLS, DUE TO WEATHER CONDITION OUR OFFICE WILL ALSO CLOSE. SAFETY IS IMPORTANT TO US ALL.

IF YOUR PHYSICAN REQUIRES THAT YOU BE PREMEDICATED PRIOR TO YOU DENTAL APPOINTMENT, DUE TO A MEDICAL CONDITION OR RECENT SURGERY, PLEASE MAKE US AWARE. WE WILL BE HAPPY TO CALL IN A PRESCRIPTION FOR YOU AS WELL. ALSO, IF YOU ARE CURRENTLY TAKING ANY BLOOD THINNING MEDICATIONS, PLEASE CHECK WITH YOUR PHYSICIAN PRIOR TO YOUR DENTAL APPOINTMENT, PLEASE BRING WITH YOU A NOTE FROM YOUR PHYSICAN REGARDING DENTAL PRECAUTIONS.

MY SIGNATURE BELOW INDICATES MY KNOWLEDGE OF AND AGREEMENT WITH ALL OF THE ABOVE:

(SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE) (PRINTED NAME) (DATE)

(IF SIGNED ABOVE BY REPRESENTATIVE, RELATIONSHIP OF SIGNER TO PATIENT) (NAME OF PATIENT IF DIFFERENT FROM ABOVE)

Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 08/05/13, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more in formation about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We 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.

Our Privacy Official: HEATHER L.M. BREUER D.M.D.

Telephone: 815-899-2222 Fax: 815-895-2424

Address: 1675 BETHANY ROAD, SUITE E SYCAMORE, ILLINOIS

Email: breuerdental@gmail.com

Acknowledgement of Receipt of Notice of Privacy Practices

HEATHER L. M. BREUER, D.M.D. DENTAL RACTICE

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____