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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Ronald L. Rasmussen, DDS, Inc.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and California privacy laws, we are required to maintain the privacy and security of your protected health information (PHI). We are also required to post in a clear and prominent location, and provide patients with this Notice of Privacy Practices, which details our privacy practices, our legal duties, and your rights concerning your PHI. This Notice is currently in effect, 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 law. If changes are made, a new Notice of Privacy Practices will be displayed in our office and will be available upon request. You may request a copy of our Notice at any time.

We will let you know promptly if a breach occurs that may have compromised the privacy and security of your PHI. We will not use or share your information other than as described here unless you tell us we can in writing. You may change your mind at any time. Let us know in writing.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following describes how PHI about you may be used in this dental office:

Treatment Services: We may use or disclose your PHI to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. Upon your written request, we will not disclose to your health insurer any services paid by you out of pocket.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations, which include quality assurance, disease management, training, licensing, and certification programs.

Other Authorizations: In addition to our use of your PHI for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.

Family Members, Friends, and Others Involved in Care: Only if you agree that we may do so, we may disclose your PHI to a family member, friend, or other person if necessary to assist with your treatment and/or payment for services. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. If you are present, then prior to use or disclosure of your PHI, we will provide you with an opportunity to object to sue uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose PHI that is directly relevant to the person’s involvement in your healthcare. Your PHI may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location, condition, or death.

Marketing/Fundraising: We will not use your PHI for marketing or fundraising purposes without your written consent. You can opt out of receiving information about our marketing or fundraisers. We will not sell your PHI without your explicit authorization.

Appointment Reminders: We may use or disclose your PHI to provide you with appointment reminders such as voicemail messages, postcards, or letters. We will use unencrypted email for communicating with you at your specific request only.

Legal Requirements: We may disclose your PHI when required to do so by law.

Abuse or Neglect: If abuse, neglect, or domestic violence is reasonably suspected, we may use or disclose your PHI to the appropriate authorities to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: When required, we may disclose to military authorities the PHI of Armed Forces personnel. Information may be given to authorized federal officials when required for intelligence, counterintelligence, and national security activities. Under certain circumstances, we may disclose PHI of inmate(s) to correctional institutions or law enforcement officials having lawful custody of the inmate(s).

Business Associates: Some services in our organization are provided through contacts with business associates. Examples include practice management software representatives, accountants, answering service personnel, etc. When these services are contracted, we may disclose your PHI to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. All of our business associates are required to safeguard your PHI and to follow HIPAA Privacy Rules.

Public Health Activities: We may disclose medical information for public health activities, to include the following: to prevent or control disease, injury, or disability; to report reactions with medications or problems with products, to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease of condition.

Additional Restrictions on Use and Disclosure: Some laws may require special privacy protections that restrict the use and disclosure of certain types of PHI: alcohol and substance use disorders, biometric information, child or adult abuse or neglect including sexual assault, communicable diseases, genetic information, HIV/AIDS, mental health, prescriptions, reproductive health, and sexually transmitted diseases. We will follow the more stringent law, where it applies to us.

Substance Use Disorder (SUD) Information: Although we are not a SUD treatment program under federal law, we may receive information from a SUD Program about you. We may not disclose SUD information for use in a civil, criminal, administrative, or legislative proceeding against you unless we have (i) your written consent, or (ii) a court order accompanied by a subpoena or other legal requirement.

Breach Notification: We will notify you any time your PHI may have been compromised through unauthorized acquisition, access, use or disclosure.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information.

We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request x-Rays, there will be a fee for any copies of films. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Details of all fees are available from the HIPAA Coordinator.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We will keep your information confidential from your health plans if you pay in cash, at your request. In some instances, we may not be required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory

explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and must explain the reason for the amendment.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy policy or have questions or concerns, please contact us. If you have concerns relating to a perceived violation of your privacy rights, to access to your health information, to amending or restricting the use or disclosure of your health information, or to requesting alternative means of communication, you may contact us using the contact information listed at the end of this Notice. You also may submit a written complaint to the Department of Health and Human Services (HHS). We will provide you with the HHS address 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 HHS.

HIPAA Coordinator: Ronald L Rasmussen, DDS

Telephone: 916 689-1100 Fax: 916 689-8447

Email: rasmussendds@frontiernet.net

Address: 7501 Hospital Drive, Suite 302, Sacramento, CA 95823

PATIENT ACKNOWLEDGEMENT OF RECEIPT Of NOTICE OF PRIVACY PRACTICES

By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment, and health care operation purposes.

I hereby acknowledge that I have received from Ronald L Rasmussen, DDS, Inc._a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how my personal health information may be used and/or disclosed both with and without my authorization. I further understand that I may contact the HIPAA Coordinator if I have any questions regarding the contents of this Notice of Privacy Practices or to file a complaint about the privacy practices.

Signature: _____

Patient Name: _____

Patient Representative (if minor): _____

Date: _____

Witness: _____
_____

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 acknowledgements
An emergency situation prevented us from obtaining acknowledgements
Other (Please Specify): _____