VanderLaan Family Dentistry

Matthew R. VanderLaan, D.D.S & Kortni L. Matteson, D.D.S

NOTICE OF PRIVACY PRACTICES

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 December 1st, 2014, 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 information 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.e 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 determination 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.

Health Oversight Activities. We may disclose your PHI to an Overnight 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.

Required by Law. We may 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 actions 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.

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

National Security. We may disclose to military authorities the health information to Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence, 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.

Security 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 as subpoena or a court order.

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 communication.

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.

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. 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 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 law 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.

Our Privacy Officer: _____

Office Address: _____

Office Phone: _____

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201
877.696.6775

Rights 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 Website 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.

Collections. If we use or disclose your PHI for collections purposes, we will do so only in accordance with the law.

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 may also 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.

Or, submit a written Complaint form to us at the following address:

Office Name:_____

OfficeFax_____

Office Email: _____

These privacy practices are in accordance with the original HIPAA Enforcement effective April 14, 2003, and undated to Omnibus Rule effectiv September 23, 2013 and will remain in effect until we replace them as specij by Federal and/or State Law.

VANDERLAAN FAMILY DENTISTRY

Matthew R. VanderLaan, D.D.S & Kortni L. Matteson, D.D.S

INFORMED CONSENT FOR DENTAL TREATMENT

Medical History Information. Please understand that it is important that you divulge all information about your medical history to your dentist. It is important that you inform us of any medicines that you are taking each time that you come to an appointment as some medications can cause harmful reactions with dental treatments, anesthetics, analgesics, antibiotics or other medications. Please be sure to provide us with a list of any allergies you have as well.

Changes in Treatment Plan. I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination (i.e. root canal needed after routine fillings, crown needed if filling gets larger than originally planned). I give my permission to the Dentist to make any/all changes and additions as necessary after consultation.

X-rays and Photos. Modern Dental x-ray equipment is extremely low-dose radiation. Diagnostic x-rays provide the dentists with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Our office takes the minimum x-rays to allow us to do a thorough exam for each patient. All patients 18 years and older will receive a full mouth series of intra-oral x-rays or a panoramic x-ray. Without these x-rays, we cannot do a complete exam of the entire mouth and jaw. We may also take photos of our patients as part of their permanent record. We will not release these photos to anyone without your permission.

Specific Problem Examinations. In the event that a patient requests only a specific problem be addressed (i.e.; broken tooth, pain in one area, etc.) this is considered a problem focused evaluation. X-rays will be taken in this specific area only, and a complete comprehensive examination will not be done. The dentist cannot diagnose problems in other areas of the mouth. Please understand that this appointment will be for the treatment/diagnosis of an emergency/urgent need. Any future treatment of other areas will require additional x-rays and a complete exam. You will not be considered a patient of record unless this examination is completed.

Requests for records/x-rays. By law we are required to keep a patient's original x-rays and record in the office. Original x-rays or records will not be released. The patient or a designated person may request copies of their x-rays or record, however, there is a fee for duplication. We also require a minimum of 5 days notice to copy x-rays. There is no fee for us to send x-rays to a specialist that we refer you to.

Restorations. I understand that care must be exercised in chewing on fillings until directed by the doctor or staff to avoid breakage of soft tissue damage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay which may result in additional charges. I understand that sensitivity may occur after a newly placed filling.

Complications. Complications resulting from the the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness, and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is transient but on infrequent occasion, may be permanent), reaction to injections, changes in bite, jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure. The risks of complications from medications used/prescribed with general dental treatment include, but are not limited to, drowsiness, lack of awareness and coordination, nausea, allergic reactions, etc. (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). Also it is important to note that antibiotics are known to decrease the effectiveness of oral contraceptives, so it is advised that other contraceptive measures be taken during the administration of antibiotics.

Minors. We must receive written consent prior to performing any non-emergency dental procedure on a minor. Grandparents, step-parents, friends, relatives, etc. are not legally allowed to consent to dental procedures, unless they have been given written consent by the parent or legal guardian. Please do not send your child to an appointment alone or with someone other than yourself, unless you have filled out any necessary consent forms prior to the appointment, otherwise we may have no choice but to reschedule your child's appointment to another day. Parents and/or authorized person accompanying a minor for treatment must remain in the office during treatment.

Specialty Referral and/or Second Opinion. General dentists perform the majority of all dental treatment today. However, we want all patients to be aware that specialty fields exist in dentistry, particularly in the fields of oral surgery, orthodontics, periodontics, pediatric dentistry, and endodontics. In some cases we ma have to refer certain procedures out to a specialist. We would be happy to offer you the names of specialists in order for you to have a second opinion and/or have actual treatment performed by a specialist.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I have I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfactions. I consent to allow VanderLaan Family Dentistry to take x-rays and perform an examination on me, and perform any agreed upon treatment today or at future appointments.

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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you, VanderLaan Family Dentistry, to use and disclose my protected health information to carry out the following:

- *Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);*
- *Obtaining payment from third party payer (e.g. My insurance company);*
- *The day-to-day healthcare operations of VanderLaan Family Dentistry's healthcare practice*

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operation, and that you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occured prior to the date I revoke this consent is not affected.

Signature of Patient: _____ Date: _____

Print Patient's Name:_____

Relationship to Patient: _____

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FINANCIAL AGREEMENT

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Payment of estimated patient portion is due at the time of treatment. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

1. **Flexible payment plans of up to 6 months upon approval with Care Credit®. Approval must be received prior to treatment date.**

2. **Cash, Check, or Visa/Mastercard/Discover/American Express.**

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services.

We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes final determination once treatment it completed and the claim is submitted. Your insurance is a contract between you and your company; therefore, all remaining charges are your responsibility.

All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process clams.

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am aware past due accounts will be subject to a charge of 1.5% per month interest. I am responsible for all collection costs incurred by the dental office and on a returned check, a fee of $40.00.

Broken Appointment Policy: I am aware that VanderLaan Family Dentistry requires an advance 24 business hours to change or reschedule an appointment, with exception to individual circumstances. Since Fridays are not a business day for our office, I must give notice on the Thursday before an appointment that is scheduled the following Monday. I understand that I will be charged $50 for any missed or broken appointments, and an additional $25 (or $75 total) for appointments 4om or later, as these are the times in highest demand.

Print Patient Name: _____ Date: _____

Signature of Patient or Legal Guardian: _____

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AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION

Patient Name: _____ Date of Birth: _____

- **I agree that the dental practice may communicate with me electronically at the email address below.**
- **I am aware that there is some level of risk that third parties might be able to read unencrypted emails.**
- **I am responsible for providing the dental practice any updates to my email address.**
- **I can withdraw my consent to electronic communications by calling 616-455-7310.**

Email Address: _____

Patient Signature: _____ Date: _____