New Era Family & Cosmetic Dentistry
2785 E. Eldorado Pkwy, Suite# 105
Little Elm, TX 75068
(972) 292-2288

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

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use of disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information 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. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related services: We will not use your health information for marketing without your written authorization.

Required by law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminder: We may use or disclose your health information to provide you with appointment reminders (such as Voicemail messages, post cards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you $25.00 to locate and copy your information, and postage if you want the copies mailed to you.
Amendment: You have the right to request that we amend your health information.

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OVER……..

QUESTIONS AND COMPLAINT

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 you disagree with a decision we made about access to your health information or in response to 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 location, you may complain to us using the contact information listed above.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR NECESSARY USE OF PERSONAL HEALTH INFORMATION

_____

Print Patient's Name Date

I, **X**_____, have received
(Signature of Patient/PARENT OR GUARDIAN)

a copy of this office's NOTICE OF PRIVACY PRACTICES as required by federal law.

I, **X**_____, consent to the use and disclosure of
(Signature of Patient/PARENT OR GUARDIAN)

my personal health information by your office during Treatment, Billing/Payment and Dental Office Operations as outlined in the Notice of Privacy Practices.