Notice of Privacy Practices

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

Oceans Orthodontics & Pediatric Dentistry

Oceans Orthodontics & Pediatric Dentistry is required by law to maintain the privacy of your protected health information (PHI) and to provide individuals with notice of its legal duties and privacy practices currently in effect with respect to PHI. This Notice describes how we may use and disclose your PHI for treatment, payment, and for health care operations as well as for other purposes that are permitted or required by law. 45 CFR 164.520.

Oceans Orthodontics & Pediatric Dentistry reserves the right to change the terms of this Notice and make the new notice provisions effective for the entire PHI we maintain. If Oceans Orthodontics & Pediatric Dentistry makes a material change to this Notice, we will post the changes promptly on our website at http://www.oceanswestfield.com. A paper copy of this Notice is available upon request.

Effective Date

This Notice of Privacy Practices became available on April 14, 2003 and was amended on July 2,2014.

Types and Uses of Disclosures of your PHI

"Treatment" – We will use and disclose your PHI to provide, coordinate or manage your dental health care and any related services. We will also disclose PHI to other providers who may be treating you such as a specialist.

"Payment" – We will use your PHI to obtain payment for the dental health care services provided. For example, we may provide information to a health insurance company or business associate to obtain payment for the treatment provided for you.

"Healthcare Operations" – We will use your PHI to support the management of our dental offices. For example, we may use information about you to conduct quality performance reviews regarding our services or the performance of our staff. Additionally, we may obtain services from business associates such as training programs, legal services, and insurance.

HITECH Amendments

HITECH Act Breach Notification Requirements: The HITECH Act requires us to notify each individual whose unsecured PHI has been, or is reasonably believed to have been accessed, acquired or disclosed due to a breach. The HITECH Act imposes a similar requirement on Business Associates. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

Restriction of Disclosure: The HITECH Acts restricts us from reusing an individual's request not to sue or disclose the individual's PHI in instances where the patient's services were paid out of pocket to prevent the information from flowing to the health plan since no claim is being made against the third party payer.

Access to Electronic Health Records (EHRs): The HITECH Act expands the right of records to access. Individuals have the right to access their HER in an electronic format and to direct us to send the e-record directly to a third party. We may only charge for the labor costs to transfer this information.

Expansion of Accounting Disclosures: The HITECH Act removed the accounting of disclosures exception of PHI to carry out treatment, payment and healthcare operations. All such disclosures must be accounted for if the disclosure is made through an HER. We also will provide the individual with a list and contact information through an EHR. We will also provide the individual with a list and contact information for all relevant business associates to obtain an accounting of disclosures of PHI.

Prohibition on Sale of PHI: The HITECH Act prohibits covered entities and business associates from receiving indirect or direct remuneration in exchange for PHI without obtaining an authorization from the individual unless such an exchange meets one of the exceptions listed by the government.

Oceans Orthodontics & Pediatric Dentistry Responsibilities

Certain Uses or Disclosures: We will use and disclose your PHI when required to by federal, state, or local law.

Appointment Reminders: We may contact you to provide appointment reminders via telephone or post cards. We may contact you to provide information about the treatment alternatives or other health-related benefits and services that may be of interest to you.

Revocation: Other uses and disclosures will be made only with your written authorization and you may revoke such authorization.

Public Health & Safety: We will use and disclose your PHI to public health authorities permitted to collect or receive information for the purpose of controlling disease, injury or disability.

Individual Rights

Request Restriction of Disclosures: You have the right to request restrictions on certain uses and disclosures of PHI and under HIPAA, Oceans Orthodontics & Pediatric Dentistry is not required to agree to the restriction unless as clarified by defined by the HITECH Act.

Right to Reserve Confidential Communication: You have the right to receive confidential communications. Please specify your preference of communication in writing to us as such as your home telephone, work telephone, mobile telephone, and/or email. We may provide relevant portions

of your PHI to a family member, relative, close friend or any other person you identify as being involved in your dental care or payment.

Right to PHI: You have the right to inspect and copy the PHI that we maintain about you in our designated record set for as long as we maintain the information. We may charge a fee for the costs of copying, mailing, or other supplies sued in fulfilling your request. Please contact the Privacy Officer to inspect your record or receive a copy.

Right to Amend: You have the right to request that we amend your health information if you feel it is incomplete or inaccurate. You must make the request in writing to our Privacy Officer stating the reasoning that supports your request. We many deny the request if the information was not created by our office or if the person who created it is no longer available to make this amendment.

Right to Accounting: You have the right to receive an accounting of disclosures of your health information as required by law. Please submit a written request to our Privacy Officer.

Right to Paper Copy: You have a right to obtain a paper copy of the Notice of Privacy Practices.

Request Information or File a Complaint

If you have questions, would like additional information or want to report a problem regarding the handling of your PHI, you may contact the Privacy Officer at

Oceans Orthodontics & Pediatric Dentistry
522 E. Broad St Suite #3
Westfield, NJ 07090
Phone: (908)654-4949
Fax: (908)301-1800
office@oceanswestfield.com

PATIENT CONSENT (MINOR)

Clinical

1. As the legal parent/guardian of _____("Patient"), I authorize Oceans Orthodontics & Pediatric Dentistry to perform all recommended treatment on the patient.
2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such diagnostic material may be released to third-party payers and/or other health professionals.
3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

1. I am responsible for payment for all services rendered on behalf of the patient. I understand that payment is due when services are rendered. I am aware that a billing fee will be automatically tabulated into my account if my balance is 30 days old or older. Should my account balance become delinquent, I will be responsible for all additional collection costs including reasonable attorney fees.
2. A $50 missed appointment fee will be charged to my account for all missed or last-minute cancellations by patient. I am aware that to hold down operating costs, a notice of at least 24 hours is required for any cancellation or change of appointment.

Insurance

1. I authorize the Practice to release to staff, hospitals, health care service plans, insurance, companies, self-insurers or their representatives, any and all information, records, and radiographs about the Patient's medical history, services rendered, or recommended treatment.
2. I authorize the Practice to submit claims for payment for services rendered rendered or preauthorizations necessary to my insurance company , on my behalf or on Patient's behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted . I am responsible for payment regardless of the coverage provided.

I have read this Patient Consent and agree to the terms and conditions herin.

_____ _____

Print Name of Patient Date of Birth

_____ _____ _____

Print Name of Parent or Legal Guardian Signature (Parent or Legal Guardian) Date

Oceans Orthodontics & Pediatric Dentistry

Your Privacy Is Important to us.

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices for Oceans Orthodontics & Pediatric Dentistry, I hereby authorize, as indicated by my signature below, for Dr. Aimee Leibowitz to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name of Patient Date of Birth

_____ _____ _____

Print Name of Parent of legal Guardian Signature (Parent or Legal Guardian) Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me at my mobile telephone number _____

☐ You may contact me at my work telephone number _____

☐ You may send me an email at _____

☐ Other _____

In some cases, it is necessary for us to speak with your child's pediatrician, orthodontist, or other specialists regarding their care. Please list doctor(s) with whom we may discuss your Protected Health Information (PHI).

1. _____ Date Added/Removed: _____
2. _____ Date Added/Removed: _____
3. _____ Date Added/Removed: _____

In addition to custodial parents and legal guardians, please list authorized persons (such as grandparents, aunts, uncles, babysitters, etc) whom you give permission to discuss your Protected Health Information (PHI), to accompany your child to appointments, update medical history and consent for treatment.

1. _____ Date Added/Removed: _____
2. _____ Date Added/Removed: _____
3. _____ Date Added/Removed: _____
4. _____ Date Added/Removed: _____

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For office use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but couldn't because:

☐ Individual refused to sign.

☐ Communication barriers prohibited obtaining the acknowledgement.

☐ An emergency situation prevented us from obtaining the acknowledgement.

☐ Other (Please specify) _____

Staff Person Initials _____