

NOTICE OF PRIVACY POLICY
Peter A. Cilento, D.M.D. and Maryam Sholehvar, D.M.D.

As per guidelines established by the Health Insurance Portability and Accountability Act (HIPAA), this notice outlines the procedures for disclosing and using your protected health information (PHI). PHI is comprised of all demographic, insurance, medical and dental information in our patient files.

Your privacy and patient rights are important to us. State and federal law has issued a standard to be followed by all health care providers in maintaining the privacy of your health information. The effective date of this notice is April 14, 2003. It will remain in effect unless and until we modify it in accordance with the law, in which case you will be given a revised notice.

HOW WE USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

- 1) For the purpose of treatment, payment and the continued operation of the office.
- 2) To facilitate your care by another dentist, physician, or health care provider who is subject to this same standard.
- 3) To assist other health care organizations that have a relationship with you to conduct quality assessment, review qualifications of health care professionals, or detect / prevent fraud and abuse.
- 4) For public benefit as required by law. For example, for disease and vital statistics reporting, child abuse, FDA oversight, adult abuse, neglect or domestic violence, to employers regarding work related injury, in response to court orders, to law enforcement officials, coroners, medical examiners, funeral directors, organ procurement agencies, in connection with research, to military or federal officials, to correctional institutes regarding inmates, and as authorized by state worker's compensation laws.
- 5) 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. Unless required by law, we cannot use your PHI unless you give us written consent.
- 6) We may disclose your information to a family member, friend, or other person to the extent necessary to help with your care or with payment for your care. In the event of a medical emergency we will disclose your medical information, which we deem to be in your best interest, using our professional judgement.
- 7) For your convenience, we provide reminder calls to our patients the day prior to their appointment. We also send reminder postcards for hygiene appointments or to remind you to schedule if we haven't seen you for some time. If for any reason you do not wish to be called or have a reminder mailed to you home, you have the right to refuse this service. Please submit any restrictions you want placed on our correspondence with you in writing.

YOUR RIGHTS AS A PATIENT

- 1) You have the right to look at or obtain copies of your PHI. If a photocopy would not suffice, you can request a different format unless it would not be feasible. To gain access to your PHI, you must make a request in writing sent to our office address. If you request a copy, we will charge you a reasonable fee to cover our expenses including postage. If you request an alternate format to photocopying, there will be a cost-based fee for that service.
- 2) You have the right to request a list of instances in which we or our business associates disclosed your health information over the previous six years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, healthcare operations, as authorized by you and for certain other activities.
- 3) You have the right to ask us to place additional restrictions on our use of disclosure of your PHI, however, we are not required to agree to such a request. If such an agreement is made in writing, we are bound by the restrictions of our agreement.
- 4) You have the right to ask us to contact you about your health information in a different way from our common practices or to a different location. You must make this request in writing and provide specifics of the alternate way you wish to be contacted and explain to our satisfaction how payment will be handled under your alternate method of communication or location of communication.
- 5) You have the right to ask that your PHI be amended. This must be in writing and adequate explanation for any changes you wish us to make must be made. Your request will be denied if it violates any state or federal laws to amend the information.
- 6) You have the right to file a complaint with our office or to the U.S. Dept. of Health and Human Services. We will not retaliate in any way if you choose to make a complaint. Complaints to the Dept. Of Health and Human Services must be made in writing. We will provide their address upon request. Complaints or questions about our handling of your PHI should be directed to one of our HIPAA Compliance Officers. These are Dr. Sholehvar and Linda Anthony. You may make an appointment to speak to either of them or address your complaint or question to:

HIPAA Compliance Officers
1104 S. Cedar Crest Blvd. Suite 100
Allentown, PA 18103
(610) 437-4486

A complete copy of the actual privacy standard issued by the U.S. Dept. Of Health and Human Services is available for your perusal at the front desk. We reserve the right to amend this policy in accordance with the law at any time. If revisions are made, a copy of the new notice or amendment will be presented to our patients at the time of their next visit.

PATIENT ACKNOWLEDGMENT FORM

Peter A. Cilento, D.M.D. and Maryam Sholehvar, D.M.D.

I, _____ acknowledge the receipt and acceptance of the Notice of Privacy Policy for the above dental office.

Patient Signature _____ SS# _____

Date _____

If someone other than the patient is signing this form on their behalf, please provide us with your name and your relationship to the patient.

Patient's Representative _____

Relationship to patient _____

If the patient does not wish to sign this form, describe your effort to have them do so. _____

Explain the reason why the patient would not sign this form.

Signature of Staff Member _____