OMS SPECIALISTS
ORAL, MAXILLOFACIAL & IMPLANT SURGERY

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I am a patient of Oral and Maxillofacial Surgery Specialists, P.A. I hereby acknowledge that I have been offered a copy of the Oral and Maxillofacial Surgery Specialists' Notice of Privacy Practices.

Name (*please print)* _____

Signature _____

Date _____

OR

I am a parent or legal guardian of _____ (*patient name*). I hereby acknowledge that I have been offered a copy of the Oral and Maxillofacial Surgery Specialists' Notice of Privacy Practices with respect to the patient.

Name (*please print)* _____

Relationship to Patient: Parent _____ Legal Guardian _____

Signature _____

Date _____

PATIENT COMMUNICATION

Family and Friends

It is the office policy of Oral and Maxillofacial Surgery Specialists, P.A. not to release confidential information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonable infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends or caretakers/babysitters, please indicate that below so that we may best serve you. If you do not want any of your medical information provided to a family member, please circle the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add names later, please confirm this in writing, or call our staff.

You may cancel this authorization to the extent allowed by law. If you do, you understand that the doctor or practice may have already released information about you after you gave permission. You understand that cancelling this authorization would not prohibit any release of information by the practice in reliance on your original authorization.

If you wish to cancel or change this agreement please call Oral and Maxillofacial Surgery Specialists or issue a letter in writing.

	Health Care Information	Financial Information
Spouse ______________________	Yes / No	Yes / No
Parent ______________________	Yes / No	Yes / No
Other ______________________	Yes / No	Yes / No
______________________	Yes / No	Yes / No
______________________	Yes / No	Yes / No

Alternative Communications

You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: ______________________________________

____

Printed Name ______________________________ Date ____________________

Signature ____

- -

FOR OFFICE USE ONLY

Changes to above, authorized by patient over the phone:

Change	Date	Staff Initials
______________________	______________________	__________
______________________	______________________	__________
______________________	______________________	__________

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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 THE INFORMATION BELOW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program which requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or verbally, are kept confidential. This act gives you, the patient, the right to understand and control how your personal health information (PHI) is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation regarding how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your PHI only for each of the following purposes; treatment, payment and health care operation.

- Treatment means providing, coordination or managing health care and related services by one or more healthcare providers. An example of this would include referring you to another specialist or communication with your general dentist.
- Payment refers to activities such as obtaining reimbursement for services, confirmation insurance coverage, billing or collections activities and utilization review. An example would be if we submitted your insurance company a bill for your visit after verifying coverage prior to the procedure.
- Health care operations includes business aspects of running our practice, such as conducting quality assessment, improving activities, auditing functions, cost management analysis and customer service.
- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible. Examples would include an investigation of abuse or neglect, identification of a deceased person or cause of death, and activities related to national defense.
- Other instances where we may disclose PHI without consent or authorization of the patient include communication with family, relatives or close personal friends in an emergency, communication with the Food and Drug Administration regarding adverse events with respect to products and product defects, and communications pursuant to workers' compensation laws.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures of your PHI will be made only with your written authorization under certain circumstances. You may revoke such authorization in writing and we are required to honor and abide by the written request, except to the extent that we have already taken actions relying on your previous authorization.

You have the following rights with respect to your PHI:

- The right to request restrictions on the uses and disclosures of your PHI to carry out treatment, payment or health care operations, and the disclosures of your PHI to your family members, relatives, close personal friends or any other persons identified by you. We are, however, not required to honor a restriction request except in limited circumstances which we will explain upon request. If we agree to the restriction, we must abide by it unless the restriction is terminated in writing by either party or in an emergency situation.
- The right to reasonable requests to receive confidential communications of PHI by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practice with respect to PHI.

This notice is effective as of February 14, 2012 and we are required to abide by the terms of the Notice of Privacy Practices and HIPAA regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your privacy rights have been violated by our office. You have the right to file a formal, written complaint with Oral & Maxillofacial Surgery Specialists, P.A. and with the Department of Health and Human Services, Office of Civil Rights with the information that is provided below. We will not retaliate against you for filing a complaint.

Please contact the Practice Compliance Officer for more information, either in person or in writing.

Oral & Maxillofacial Surgery Specialists, P.A.
Attention: Melissa Calumpit
550 County Road D, Suite 12
New Brighton, MN 55112

Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue SW
Washington, D.C. 20201
Phone: 877-696-6775
https://www.HHS.gov