BECK DENTAL CENTER, P.C.

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.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect ____/____/____, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you 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.

Payment: We may use and 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. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.______ for each page, $______ per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

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 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 also may 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.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: ______________________________

Telephone: ______________________ Fax: ______________________

E-mail: ______________________________

Address: ______________________________

© 2002, 2009 American Dental Association. All rights reserved.

Reproduction and use of this form by dentists and their staff for non-commercial use is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ______________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

______________________ ______________________

Please **print** name of Patient Please **sign** for Patient / Guardian of Patient

______________________ ______________________

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: ______________________

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other ______________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ______________ Relationship: ______________

Name: ______________ Relationship: ______________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ **Any of the Above**
☐ Text Message ☐ **None of the above** (opt out)
☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

____
Signature of Privacy Officer

HIPAA made EASY™
©All Rights Reserved

AUTHORIZATION, RELEASE AND AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize the Beck Dental Center, P.C. to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health practitioners necessary for obtaining payment of services performed and/or treatment to be rendered.

I authorize and hereby request my insurance company to pay directly to the Beck Dental Center, P.C. any insurance benefits otherwise payable to me. I understand that I am responsible for knowing what my dental benefits, coverage's, limitations and and exclusions are, as well as determining whether Beck Dental Center, P.C. is affiliated with my insurance plan. I understand that my dental insurance carrier may pay less than the actual bill for services rendered as a result of these individual contract limitations and or exclusions. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

If I do not pay the entire new balance owed within 30 days of the monthly billing date, a late charge of 1.5% per month on the balance then unpaid and owed will be assessed, as allowed by state law.

I realize that failure to keep the account current may result in my being unable to receive dental services except for dental emergencies or where there is prepayment for additional services.

In the case of default on payment of this account, I agree to pay collections costs, billing fees, accrued interest charges, court costs and reasonable attorney fees incurred in the attempt to collect on this amount or any future outstanding account balances.

I authorize the conversion of any paper checks presented whether in person or by mail to ELECTONIC FUNDS TRANSFER (EFT) and the debiting of my account for payment on my account. If the EFT or check returns unpaid, I agreed to pay the EFT or check plus any and all applicable fees or the maximum fee allowed by state law by EFT (s) or check debit (s) to my account.

I acknowledge receipt of the WELCOME LETTER that explains the office policies.

I understand that a minimum of 48 hours notice must be given for cancellation or rescheduling of an appointment(s) or an administrative fee of $50 for a weekday appointment or $100 for a Saturday appointment will be applied to my account for each appointment scheduled that day. I further understand a LATE ARRIVAL that prevents sufficient time to complete the scheduled procedure(s) will be considered a NO SHOW and the previously stated pertinent fee(s) will be charge to the account. I understand that I am responsible for payment of said fee.

I further understand that any and all estimated co-pays and or deductibles are due and payable at the time services are rendered.

(For your convenience we offer the following methods of payment: CASH, PERSONAL CHECK, DEBIT CARD, ALL MAJOR CREDIT CARDS and CARE CREDIT. Please ask for details on CARE CREDIT.)

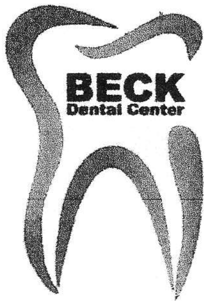
Print Patient Name: ______________________________ *Date:* ______________________

*X*____

Signature Patient, Parent, Guardian or Personal Representative

---

Thank you for your co-operation. Your compliance with the above agreement allows us to more effectively and efficiently meet your dental needs. If you have any questions regarding your treatment or account at any time, please ask. We are always happy to assist.



BECK DENTAL CENTER, P.C.
Richard L. Beck, D.D.S.
233 E. 84TH Dr., Suite 106
Merrillville, IN 46410
Phone: 219.736.2309
Fax: 219.736.2328
E-mail: beckdentalcenter@gmail.com

AUTHORIZATION TO RELEASE RECORDS AND/OR RADIOGRAPHS

Accurate diagnosis and treatment planning requires radiographs (x-rays). If you have had any dental radiographs taken at your previous dental office - bitewings (2-4 films) within the last year, panoramic (pano) or full-mouth series (18-22 films) within the last 5 years, we request they be forwarded to our office for our records.

Your insurance carrier places a limitation on the frequency that radiographs may be taken to be covered as a benefit on you policy. If they are not covered as a result of this frequency the patient or guarantor are responsible for the cost of a new one/set to be taken in order to provide you with an accurate diagnosis.

Please complete the following to facilitate our efforts on your behalf to obtain these needed diagnostic tools:

Previous Dental Office Name: ______________________ Phone: ______________

Patient Name: ______________________ Birthdate: ______________

Address: ______________________________________

City: ______________________ State: __________ Zip: __________

Additional family members to include with this request:

Name: ______________________ Birthdate: ______________

Name: ______________________ Birthdate: ______________

Name: ______________________ Birthdate: ______________

I, ______________________, hereby authorize the release of any current dental records and/or radiographs of the above listed patients. I further request this information be forwarded either by e-mail or mail to the office listed above.

Signature: ______________________ Date: ______________
Patient, Parent or Guarantor