ADVANCED FAMILY DENTISTRY,LLC

300 PRINCETON-HIGHTSTOWN RD, BLDG A SUITE#104
EAST WINDSOR NJ 08520 (609)443-6700

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND/OR DISCLOSED AND HOW YOU CAN GET ACCESS FOR THE SAME. PLEASE REVIEW IT CAREFULLY.

USES AND DICLOSURES

TREATMENT: ***Your medical information may be used or disclosed by staff members to other health professionals for evaluating your health, diagnosing medical conditions and providing treatment like results of tests and procedures would be available to all health professionals who may provide treatment or who may be consulted by staff members.***

PAYMENT: ***Your health information may be used to seek payment from your health plan, other sources of coverage or crdit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services provided and the condition being treated.***

HEALTH CARE OPERATIONS: ***Your health information may be used to support the day-to-day activities and management of this office like to support budgeting and financial reporting.***

LAW ENFORCEMENT: ***Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspection, facilitate investigations, and to comply with government mandated reporting.***

PUBLIC HEALTH REPORTING: ***Your health health information may be disclosed to public health agencies as required by law to report certain communicable diseases to the state public health department.***

OTHER USES/DISCLOSURES REQUIRE YOU AUTHORIZATION: ***Disclossure of your health information or its uses for any other purposes other than listed above require your written authorization. If you change your mind after authorizing a use/disclosure of your information you amy submit a written revocation for the same. However that may not affect or undo any use/disclosure that occured before you notified us of your decision.***

ADDITIONAL USES OF INFORMATION

APPOINTMENT REMINDERS: ***Your information may be used by our staff to send you appointment reminders.***

INFORMATION ABOUT TREATMENT: ***Your information may be used to send you information about tratment and management of your medical condition that may be of interest for you. We may also send you information about other health related goods and services that may interest you.***

INDIVIDUAL RIGHTS

Under the federal privacy standards, your rights are:

- ***Right to request restriction on use/disclosure of your protected health information.***
- ***Right to receive confidential communications about your medical condition and treatment.***
- ***Right to inspect and copy your protected health information.***
- ***Right to amend or submit corrections to your protected health information.***
- ***Right to receive and acoounting of how and to whom your information has been disclosed; and***
- ***Right to receive a printed copy of this notice.***

THIS OFFICE DUTIES

We are required by law to maintain the privacy of your protected health information and provide you with this notice and also to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

A s permitted by law, we reserve the right to amend or modify our privacy policies and practices which mat be required by changes in federala nd state lawss and regulations. Whatever the reason, we will provide you with a revised notice on your next visit which would be applied to your protected health information that we maintain.

COMPLAINTS

If you would like to submit a comment/complain about our privacy policies or if you believe that your privacy rights have been violated you can do so by sending a letter outlining your concerns at the above address.

EFFECTIVE DATE: THIS NOTICE IS EFFECTIVE ON OR AFTER APRIL 13, 2003.

Advanced Family Dentistry, LLC
East Windsor Medical Commons
300A Princeton-Hightstown Road, Suite 104
East Windsor, NJ
08520
(609) 443-6700

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

* You may refuse to sign this Acknowledgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please print name

____
Signature

____
Date

For Office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign
____ Communications barriers prohibited obtaining the acknowledgment
____ An emergency situation prevented us from obtaining acknowledgement
____ Other (Please Specify)

____
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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ____________________ **Email:** ____________________

Patient #: ____________________ **Social Security #:** ____________________

SECTION B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected heath information to carry out treatment, payment activities and healthcare operations. **Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of your treatment, payment activities and healthcare operations, of the uses and disclosers we may make of your projected health information and of other important matters about your protected health information. A copy of Notice accompanies this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice by calling

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Right to revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to contact person listed above. Please understand that revocation of this consent will not effect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I, ____________________ have had the full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclose of my protected health information to carry out treatment payment activities and healthcare operations.

Signature ______________________________ Date ____________________

REVOCATION OF CONSENT

I revoke my Consent for your use and discloser of my protected health information for treatment, payment activities and health operations. I understand revocation will not affect any action you took before you received this written notice and you may decline to treat or continue to treat me after I have revoked my consent.

Signature ______________________________ Date ____________________

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