



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 **June 1st, 2010**, and will remain in effect until we replace it.

We may change our privacy practices from time to time. If we do, we will revise this Notice so you will have an accurate summary of our practices. The revised Notice will apply to all of your health information. We may also revise this notice from time to time. If we make any material revisions to this Notice, we will provide you with a copy of the revised Notice which will specify the date on which such revised Notice becomes effective. We are required to abide by the terms of the Notice that is currently in effect. 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

A. Use and Disclosure for Treatment, Payment, and Health Care Operations

We must disclose your health information to you, as described in the Patient Rights section of this Notice. We also use and disclose health information about you for treatment, payment, and health care operations. For example:

- **Treatment:** We may disclose your health information to a physician or other health care provider providing treatment to you.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **Health care Operations:** We may use and disclose your health information in connection with our health care operations, including quality assessment and improvement activities, review of the competence or qualifications of health care professionals, evaluation of practitioner and provider performance, training programs, accreditation, certification, and licensing and credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or health care 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.

Disclosures To Your Family and Friends: We may disclose your health information to a family member, friend, or other person identified by you to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Disclosures To Persons Involved in Your Care: We may also 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, 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 use or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, and we will disclose only health information that is directly relevant to the person's involvement in your health care. 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.

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

Patient-Related Communications: We may use or disclose your health information to provide patient-related communications such as intraoral photography, "no cavity club" for children, and telephoned-in prescriptions.

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

B. Use and Disclosure for the Public Need

In particular situations involving the public need, we may disclose your health information without obtaining your authorization. Those situations include the following circumstances:

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

Public Health Activities: We may disclose your health information to authorized public health officials so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury, or disability.

Health Oversight Activities: We may release your health information to government agencies authorized to conduct audits, investigations, and inspections, as well as civil, administrative or criminal investigations, proceedings, or actions.

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.

Product Monitoring, Repair and Recall: We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits And Disputes: We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your health information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

Law Enforcement: We may disclose your health information to law enforcement officials for certain reasons including to comply with court orders or laws that we are required to follow, and to assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person.

To Avert a Serious and Imminent Threat to Health or Safety. 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. In such cases, we will only share your information with someone able to help prevent the threat.

National Security: We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may also disclose to military authorities the health information of Armed Forces personnel under certain circumstances. If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined.

Coroners, Medical Examiners and Funeral Directors. In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

C. Partially De-Identified Health Information

We may use and disclose "partially de-identified" health information about you for public health and research purposes, or for business operations, if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will not contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. If we maintain your health information in electronic format, you may request a copy of your information in electronic format and we will charge you no more than our cost of preparing the materials. If we maintain your information in paper files, you may request photocopies or copies in another format. We will use the format you request unless we cannot practically and reasonably do so. If you request an alternative format, we may charge a cost-based fee for providing your health information in that format. 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.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years or such shorter time as you may specify. That accounting would not include disclosures made for the purposes of treatment, payment, or health care operations, unless we maintain your health record electronically, in which case, after January 1, 2011, we may need to provide you with an accounting of treatment, payment, or health care operations disclosures for no more than 3 prior years, but not including any treatment, payment, or health care operations disclosures prior to January 1, 2011. 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.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. If we agree to your request, we will abide by our agreement except in an emergency situation. However, we are not required to agree to these additional restrictions, except that we must agree to a request that we restrict disclosure of your information to a health plan for purposes of payment or health care operations if the information pertains solely to a health care item or service that you have paid for out of pocket and in full.

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 a satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment of Health Information: 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.

Notification of Breach of Unsecured Health Information: Our policy is to encrypt our electronic files containing your health information so as to protect the information from those who should not have access to it. If, however, for some reason we experience a breach of your unencrypted health information, we will notify you of the breach.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you have the right to request a paper copy of this Notice. You may make such a request by writing to the address provided at the end of this Notice.

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 INFORMATION

Chad Thompson, Corporate Compliance Officer
1200 Network Centre, Suite 2
Effingham, Illinois 62401
(217) 540-5100



FINANCIAL AGREEMENT

Thank you for choosing us to provide your dental care. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business office staff.

DENTAL INSURANCE As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or consider "usual, customary and reasonable" all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment.

PAYMENT POLICY

- We accept cash, personal checks, debit cards, Visa, MasterCard, American Express, and Discover. For those who qualify, we also accept Care Credit. Care Credit offers no interest financing for up to twelve months. If you choose to pay cash in full, before the treatment day we will gladly extend a 5% cash savings.
- After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance.

- We do not file claims for medical insurance or more than one dental insurance company per patient.

PATIENTS WITHOUT INSURANCE COVERAGE

We provide written estimate of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS

The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

RETURNED CHECKS

A \$25.00 charge applies when a check is returned by the bank.

We understand temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

FINANCIAL AGREEMENT CONTINUED OVERDUE BALANCE

An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: an interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

CONSENT & AUTHORIZATION

I hereby do authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understand this document in its entirety, outlining office policies and financial policies of Dr. Marvin Berlin, Dr. Jeff Lynch, Dr. Matthew Markham, and Dr. Aaron Wood DDS, PC. Without any reservations, I agree to abide by the policies outlined herein.

FORM COMPLETED BY

Name _____ Signature _____

IN CASE OF A CHILD: Relationship to child

_____ Date _____ Are you the
person legally responsible for this child? Yes _____ No _____ Reviewed by staff member
_____ Date _____



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

PERMISSION TO DISCUSS DENTAL TREATMENT

In the event that you may want a **family member or friend** to discuss your dental treatment with our office, we must have permission/consent in writing from you to do so. In section "A" please list any person you give Mckinneydentist.com permission/consent to discuss your information such as xrays, account information, treatment, etc.

If you do not wish to give consent to any person, please check section "B" below, sign and date the bottom portion of this form. You must choose one option.

**** If the patient is a minor, we will discuss dental treatment with either parent or guardian****

A. ___ I hereby give permission/consent to Mckinneydentist.com to discuss any and all dental information with the named individuals below.

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

B. ___ I do not wish Mckinneydentist.com to discuss any of my dental treatment with anyone other than me.

Health Insurance Portability & Accountability Act-HIPAA

I, _____, understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ Date: _____

