



We would like to welcome you and your family to
Van Westen orthodontics

Where Smiles Come Together for a lifetime

Notice of Privacy Practices

Van Westen orthodontics is required by law to maintain the privacy of Protected Health Information (known throughout this notice as PHI), to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of PHI.

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, and to make new Notice provisions effective for all protected health information that we maintain. When we make an important change to our privacy practices, we will post the new Notice on our website at vwbraces.com. We will provide copies of the new Notice upon request.

USE OF PROTECTED HEALTH INFORMATION (PHI)

We may disclose your health information for different purposes, including treatment, payment and healthcare operations. The following examples describe the categories of our uses and disclosures. Please note that not every use or disclosure in each category is listed.

Treatment. We may use and disclose your medical/dental information to a dentist, physician, or other healthcare provider in our healthcare team who are involved in your care. Different healthcare professionals, such as pharmacists, lab technicians, and radiology technicians, may also share information about you in order to coordinate your care. In addition, we may send information to a dentist or physician who referred you to the Van Westen orthodontics, or other healthcare providers not affiliated with Van Westen orthodontics who are involved with your care. At all times we will comply with any regulations that apply.

Payment. We may use and disclose your PHI to bill and collect payment for the treatment and services provided to you. For example, we may provide PHI to an insurance company or other third party payor in order to file a claim in your behalf or obtain approval for treatment.

Appointment Reminders and Health related Benefits or Services. We may use your PHI to provide appointment reminders such as voicemail messages, postcards, letters or emails.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your PHI to your family, friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to your representative. If person has the authority by law to make healthcare decisions for you, we will treat your representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your PHI to assist in disaster relief efforts.

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

Secretary of HHS. We will disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

National Security, Law enforcement and Legal Process. We may disclose your PHI to government agencies and law enforcement personnel when required by law.

Judicial Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI to a court or administrative order. We also may disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Public Health Activities. We may disclose your PHI for public health activities, including disclosures to: Prevent or control disease, injury or disability; report child abuse or neglect; report reactions to medications or problems with products or appliances; notify a person of a recall, repair, or replacement of products or appliances; notify a person who may have been exposed to a disease or condition; notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and report a death.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation.

Disclosures to Family, Friends, or Others. You may authorize us to provide your PHI to a family member, friend, or other adult(s) in writing by signing our **Authorization for Release of Protected Health Information**. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke the authorization at any time by sending a written notice to [Van Westen orthodontics](#). Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action.

YOUR RIGHTS REGARDING PHI

Access. You have the right to review or get copies of your PHI. To obtain access to your PHI you must make the request in writing by using our **Consent to Release of Dental Records** form. A reasonable cost-based fee will be charged to make copies of radiographs, facsimiles, or other formats of PHI.

Request restrictions. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to grant your request except in the case where the disclosure is to a health plan for the purposes of carrying out payment or healthcare operations and the information pertains solely to a healthcare item or service for which you, or a person on your behalf (other than the health plan) has paid us in full.

If you pay for a service or dental care item out-of-pocket in full, you can request us not to disclose your PHI to your insurance company unless a law requires us to share your information.

Disclosure accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit

your request in writing. 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 the additional requests.

Request confidential communications. You have the right to request that we communicate with you about your health information by alternative means or locations. You must make your request in writing and must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Amend information. You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it.

Notification of a breach. You be notified of breaches of your PHI as required by law.

QUESTIONS AND COMPLAINTS

You may contact Dr. Van Westen directly if:

- You would like more information about our privacy practices
- You wish to comment on a request to amend, restrict the use or disclosure of PHI
- You disagree with the decision we have made about access to your PHI
- You feel that we may have violate your privacy rights

You may contact US Department of Health and Human Services for further information about HIPPA or to file a complaint.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I confirm that I have read, understood, and agree to the information discussed above.

Patient name (PRINT) Patient's birthdate ___/___/___

Parent or Guardian (PRINT)

Patient / Parent or Guardian (SIGNATURE) Today's date ___/___/___

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

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

___ An emergency situation prevented us from obtaining signature

___ Other: Specify: _____