

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 IT CAREFULLY

Our pledge regarding your health/medical information:

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

The Health Insurance Portability and Accountability Act of 1996, HIPAA requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, is kept confidential.

This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Treatment – means providing, coordinating, or managing health care and related services by one or more health care providers. An example of treatment would include root canal, retreatment, and surgery.

Payment – means obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example would be billing your insurance for dental treatment received.

Health Care Operations – includes the business aspects of running our practice, auditing functions, cost management analysis, and customer service.

Your confidential information may be used to confirm your appointment by phone or to provide you with information about treatment alternatives or health related services. This office uses various communications between patients and health care providers to obtain information for your chart/records. Any other use and disclosures will be made with your written authorization. You may revoke such authorization in writing.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. The revisions will be posted on the effective date and you may request a copy of the revised notice from our office.

You have the right to file a formal, written complaint to us or with the Department of Health & Human Services in the event you feel your privacy rights have been violated. If you want more information about our privacy practices or have questions or concerns, please contact us.

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, DC 20201
877-696-6775

Sherman & Miller, P.A.
200 Doctors Drive, Suite B
Jacksonville, NC 28546
910-577-4330
Attn: Peggy

Effective Date: April 14, 2003 / Revised May 18, 2011

Privacy Practices Acknowledgment

I have been provided an opportunity to obtain/review the Notice of Privacy Practices.

Print Name: _____

Birth Date: _____

Signed: _____

Date: _____

Parent/Guardian Signature: _____
if patient is under 18 years of age

Please list any family members or patient representatives you would like to share in your Protected Medical Information:

For Office Use Only

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

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

