Effective date of notice 01/01/07

**NOTICE OF PRIVACY PRATICES**

**Marshpoint Dentistry**

**107 charlotte rd Suite H**

**Savannah, GA 31410**

**912-898-0090**

**Fax : 912-898-0092**

**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.**

We respect our legal obligation to keep health information that identifies your private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

**TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting an appointment for you, examining your teeth , prescribing medications and faxing them to be filled: referring you to another doctor or clinic for other health care or services or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purpose are: asking you about your health or dental care plans or other sources of payment, preparing and sending bills, or claims, and collecting unpaid amount (either ourselves or through a collection agency or attorney). “Health care operations” mean those administrative and managerial functions that we have to do in order to run our office. Example of how we use or disclose your health information for health care operations are: financial or billing audits, internal quality assurance; personnel decision, participation in managed care plans, defense of legal matters, business planning and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons we usually will not ask you for special written permission.

**USES AND DISCLOSED FOR OTHER REASONS WITHOUT PERMISSION**

In some limited situations the law allows or requires us to use or discloses your health information without your permission. Not all these situation will apply to us: Some may never come up at our office at all. Such uses or disclosures are:

* When a state or federal law mandates that certain health information be reported for a specific purpose;
* For public health purpose , such as contagious disease reporting , investigation or surveillance and notice to and from the Federal Food and Drugs Administration regarding drugs or medical devices;
* Disclosure to governmental authorities about victims of suspected abuse, neglect or domestic violence;
* Uses and disclosures for health oversight activities, such as for the licensing of doctors ; for audits by Medicare or Medicaid ; or for investigation of possible violation of health care laws;
* Disclosure for judicial and administrative proceeding, such as in response to subpoenas or orders of courts or administrative agencies.
* Disclosures for law enforcement purpose, such as to provide information about someone who is or is suspected to be a victim of a crime, to provide information about crime at our office; or to report a crime that happen somewhere else.
* Disclosure to a medical examiner to identified a dead person or to determine the cause of death, or to funeral director to aid in burial; or to organizations that handle organ or tissue donations;
* Uses or disclosures for health related research;
* Uses and disclosures to prevent serious threat to health or safety ;
* Used or disclosure for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities ; for military purpose of the evaluation and health of members of the foreign service
* Disclosures of de-identified information;
* Disclosures relating to work’s compensation programs;
* Disclosure of a “limited data set” for research, public health or health care operation;
* Incidental to “business associates” who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friend who are helping you with your dental care.

**APPOINTMENT REMINDERS**

We may call or write to remind you of scheduled appointment, or that is time to make a routine appointment. We may also call or write to notify you of other treatment or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answer your phone of you are not at home.

**OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosure of your health information unless you sign a written “authorization form”. The contest of an “authorization form” is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if is your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form; or you can use one of our. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign it the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person name at the beginning of this notice.

**YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your health information, you can:

* Ask us to restrict our uses and disclosures for purpose of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restriction that you want. To ask for restriction, send a written request to the office contact person at the address, fax or email show at the beginning of this notice.
* Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate these request if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communication, send a written request to the office contact person at the address, fax or,E-mail show a the beginning of this notice.
* Ask to see or to get photocopies of your health information, by law there are a few limited situation in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us ( or

Sixty days if the information is stored off site). You may have to pay for photocopies in advance. If we denied your request, we will send you a written explanation, and instruction about how to get an impartial review of our denial if one is legally available. By the law, we can have on 30 day

Extension of the time for us to give you access or photocopies if we send you a written notice of

the extension. If you want to review or get photocopies of you health information, send a written request to the office contact person at the address, fax or E-mail show at the beginning of this notice.

* Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree we will amend the information within 60 days from when you ask us. We will send the corrected information to person who we know got the wrong information, and other that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is include in your health information, we will send it along whenever we make a permitted disclosure of your health information, by law we can have one 30 days extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask you to amend your health information, send a writing request including your reason for the amendment to this office contact person at the address , fax or

E-mail show at the beginning of this notice.

* get a list of the disclosure that we have made of your health information within the past six years( or shorter period if you want ) by law, the list will not include disclosures for purposes of treatment, payment or health care operations, disclosure with your authorization, incidental disclosure, disclosures required by law, and some other limited disclosure. You are entitled to one such list per year without charge. If you want more frequent list, you will have to pay for them in advance. We will have to pay for them advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 days extension of time if we notify you of the extension, fax or E-mail show at the beginning of this notice.
* get additional paper copies of this Notification of Privacy Practices upon request. It does not matter whether you get ones electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at address, fax or E-mail at the beginning of this Notice.

**OUR NOTICE OF PRIVACY PRACTICE**

By law, we must abide by the terms of this notice of privacy practice until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this notice, the new privacy practice will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our notice of privacy practice, we will post the new notice in our office, have copies available in our office and post it on our web site.

**COMPLAINTS**

If you think that we have not property respected the privacy of your health information, you are free to complain to us or the U.S Department of Health and Human Services, office for civil rights. We will not restate against you if you make a complaint. If you want to complain to us, send a written complain to the office contact person at the address, fax or E-mail show at the beginning of this notice if you prefer, you can discuss your complain in person or by phone.

**FOR MORE INFORMATION**

If you want more information about our privacy practice, call or visit the office contact person at the address or phone number listed at the beginning of this Notice.

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**ACKNOWLEDMENT OF RECEIPT**

I acknowledge that I receive a copy of Dr.Natalie Wermurth Notice of Privacy Practices.

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_