

NOTICE OF PRIVACY PRACTICES

Expert Dental P.C.
Yi-Ling Shiao, D.D.S.
Phone: 212-682-2965 Fax: 347-402-7697
110 East 40th Street Suite 104, New York, NY 10016

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 DENTAL INFORMATION

The privacy of your dental information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our dental office. We need this record to provide you with the quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share dental information about you. We also describe your rights and certain duties we have regarding the use and disclosure of dental information. Throughout this notice we refer to your medical information as dental information.

OUR LEGAL DUTY

Law Requires Us to:

1. Keep your dental information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your dental information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all dental information that we keep, including information previously created or received before the changes.

Notice of Change of Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR DENTAL INFORMATION

The following section describes different ways that we use and disclose dental information. For each kind of use or disclosure, we will explain what we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose dental information. We will not use or disclose your dental information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use dental information about you to provide you with dental treatment or services. We may disclose dental information about you to doctors, nurses, technicians, or other people who are taking care of you. We may also share dental information about you to other healthcare providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your dental information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your dental information.

FOR HEALTHCARE OPERATIONS: We may use and disclose your dental information for our healthcare operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your dental information for treatment, payment, and healthcare operations, we may use and disclose dental information for the following purposes.

Notification: We may use and disclose dental information to notify or help notify: a family member, your personal representative or another person responsible for your care. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your healthcare, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, dental supplies, x-ray or other dental information for you.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of dental information.

Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the dental information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use dental information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose dental information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your dental information with law enforcement officials. We may share limited information with a law enforcement official concerning the dental information of a suspect, fugitive, material witness, crime victim or missing person. We may share the dental information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your dental information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your dental information to persons subject to jurisdiction of the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose dental 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. We may share your dental information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share dental information when necessary to help law enforcement officials capture a person who may be part of a crime or has escaped from legal custody

Workers Compensation: We may disclose dental information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose dental information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose dental information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain type of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use disclose dental information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Dental Services: We may use and disclose dental information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

Security and Quality Control: For quality control purposes as well as the safety of our staff and patients, operatories and exam rooms may be under closed circuit video surveillance. By execution of this notice, you acknowledge and agree to such video surveillance to satisfy the quality control of this facility and to promote the safety and security of our patients and staff.

YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your dental information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. **You must make your request in writing.** It may take up to **3 weeks** for us to have the information ready for you. You may get the form to request access by using contact information listed at the beginning of this notice. You may also request access by sending a letter to the contact person listed at the beginning of this notice. If you request copies, we will charge you **\$0.75** for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the beginning of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your dental information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your dental information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your dental information by different means or to different locations. Your request that we communicate your dental information to you by different means or at different locations must be made in writing to the contact person listed at the beginning of this notice.
5. Request us to change parts of your dental information. We may deny your request if we did not create the information you want to change or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

Expert Dental PC
110 East 40th Street Suite #104
New York, NY 10016

You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide the address to file your complaint with the U.S. Department of Health and Human Services. Filing a complaint will in no way affect the care provided to you by this dental organization.

Terms and Conditions of Treatment-Patient Consent

I acknowledge that I have reviewed the Notice of Privacy Practices with respect on how medical information about me may be used and disclosed by Expert Dental P.C. and how I may obtain access to this information. I understand that it is my responsibility to inform the office of any information concerning my health or physical and mental condition that may be relevant to my care.

Financial information

As a condition for treatment at Expert Dental P.C., financial agreement is made in advance. Patients are responsible for the cost incurred for the dental treatment agreed upon by the patient. Patient who carry dental insurance understand that all dental services performed are charged directly to the patient and that he or she is personally responsible for the payment of their dental care. Payment may be made with cash, credit card, care credit payment plans and any other payment arrangement that is authorized by the office in advance. Any account balance over 30 days will be charged interest at a rate of 1.75% per month and/or late fees and service charges, where applicable. We require 24 hours notice for cancellation of appointments or you will be charge \$40 for missed appointments without proper notice. Most Insurance companies will not reimburse the cost of a missed appointment.

Dental Insurance

Insurance is only an estimate of benefits. We do not have a contract with your insurance company, only you do. We can only assist you in estimating your portion of the cost of treatment. The type of plan chosen by you and/or employer determines your benefits. As such, we have no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. Insurance and patient portions are estimates provided as a courtesy. In the event that your insurance carrier pays less than the estimated amount, you are fully responsible for the unpaid balance. Submission of insurance claims and/or adjustment of fees may not be done retroactively. I understand that I am responsible for all co-payments and deductibles at the time of service.

Authorization for Signature on File

Patient release of information and acknowledgement of financial responsibility. I, _____, hereby authorize Expert Dental P.C. to affix my name to any and all claims and documents as related to any and all health benefits due to me.

To the extent permitted under applicable law, I authorize release of any information relating to the claim. The "Signature On File" will be valid from this date until withdrawn. A photocopy of this document may act as an original.

I have read the above notice of privacy practices and acknowledge and agree to the terms and conditions set forth herein.

Signature of patient _____ Date: _____
Initial _____
Print Name of patient _____