# Notice of Privacy Practices

## Little Teeth of Texas Dentistry for Children, P.A.

**This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review carefully. If you have any questions about this Notice please contact our Privacy Officer.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by federal law to give you this **Notice** and to maintain the privacy of your health information. We must also abide by the terms of this **Notice** while it is in effect. We reserve the right to change our privacy practices and terms of this **Notice** at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

### How We May Use and Disclose Your Protected Health Information

When we give you our **Notice of Privacy Practices**, you will be asked to sign an **Acknowledgement of Receipt**. Once you have received our **Notice** and signed the **Acknowledgement**, we will use your protected health information for treatment, payment and health care operations. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your signature on the Acknowledgement of Receipt as soon as reasonably possible after the delivery of treatment. The following examples show how the types of uses and disclosures of your protected health information that our office is permitted to make.

**Treatment:** Your protected health information may be used and disclosed by our office and others outside of our office that are involved in your dental care. We will use and disclose your protected health information to other dentists and physicians to provide, coordinate, or manage your health care. For example your protected health information may be provided to another dental specialist to whom you have been referred to insure that the necessary information is available to diagnose or treat you.

**Payment:** Your protected health information may be used and disclosed to pay your health care bills. Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

**Healthcare Operations:** We may use or disclose your protected health information in order to support the business activities of our practice. Healthcare operations include quality assessment activities, employee review activities, licensing or credentialing activities, conducting training and conducting auditing or review activities. For example, we may use a sign-in sheet at the reception desk where you will be asked to sign your name and indicate your doctor. We may also call your name in the waiting room when your doctor is ready to see you. We may send you reminder postcards or telephone you to remind you of an appointment. We may also send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials **not** be sent to you.

**Business Associates:** We may share your protected health information with third party Business Associates that perform various activities for our practice. Whenever we disclose your protected health information to a business associate, we will have a written contract that will protect the privacy of your protected health information.

### Your Written Authorization Is Required For Other Uses Of Your Protected Health Information

Any other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that our office has already released your health information as provided for in you authorization.

### Use and Disclosure Provided Without Authorization But With An Opportunity To Object

**Family Members and Friends:** Unless you object, we will disclose to your family member, a relative, a close friend or any other person you select, your protected health information to the extent necessary to help with your dental care or with payment for the services we have provided. We will also use our professional judgment and common practice to make reasonable decisions in your best interest in allowing a person to pick up dental supplies, x-rays, prescriptions or other similar forms of health information.

**Other Disclosures That May Be Made Without Your Authorization**

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

**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. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or that of other persons.

**Military Personnel and National Security:** We may disclose the health information of Armed Forces personnel when requested by command military authorities. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities.

**Workers Compensation & Health Oversight Activities:** We may disclose your protected health information to comply with Worker's compensation Laws and health oversight agencies when conducting investigations or inspections as authorized by law.

**Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required, to the Department of Health and Human Services when determining our compliance.

**You Have The Following Rights**

**Inspect and copy your protected health information.** You have the right to look at and make copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make the request in writing to obtain access to your health information. You may obtain access by sending a letter to our Privacy Officer listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

**Request a restriction of your protected health information.** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

**Request alternative communication.** You have that 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 the alternative location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Request an amendment of your health information.** You have the right to request that we amend or correct your health information. Your request must be in writing. The request must explain why the information should be amended or corrected. We may deny your request under certain situations.

**Receive an accounting of disclosures we have made of your health information.** You have the right to an accounting of disclosures of your health information that occurred after April 14, 2003. This accounting will be for purposes other than treatment, payment or other health care operations, or disclosures we may have made to you, to family members or friends involved in your care. The right to receive this information is subject to some exceptions. If you request this accounting more than once in a 12 month period, we may charge you a reasonable cost-based fee.

**Make a complaint about our privacy practices.** If you are concerned that we have violated your privacy rights, you may file a complaint with our privacy officer using the contact information listed at the bottom of this page. You may also file a complaint with the Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint or change the way we treat you.

**You obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this notice electronically.**

**Effective Date:** July 1, 2006

**Privacy Officer:** Shawna Billick-Gerling D.D.S.

**Telephone Number:** (210) 497-8787

**Address:** 21714 Hardy Oak, Suite 102
San Antonio, TX 78258

# Acknowledgement Of Receipt
# Of
# Notice Of Privacy

I, _____ have reviewed a copy of
(Parent or Legal Guardian's Name)

Little Teeth of Texas Dentistry for Children, P.A. **Notice of Privacy Practices**

Regarding my son/daughter _____.
(Patient's Name)

_____ _____/_____/_____
(Parent or Legal Guardian's Signature) (Date)

**Staff Will Fill Out This Section If Patient's Signature Not Obtained**

Our office made a good faith effort to obtain **Acknowledgement Of Receipt** of our Notice Of Privacy Practices, but it could not be obtained for the following reasons:

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining the patient or Legal Guardian's signature.

_____ Language barriers kept us from obtaining the patient or Legal Guardian's signature.

_____ Other _____