Theresa Villano, DDS Ygnacio Valley Rd, Suite 110 Walnut Creek CA 94598 (925) 937-2273

NOTICE OF PRIVACY PRACTICES

Your Rights Under HIPAA

Effective Date: _____

OUR COMMITMENT TO YOUR PRIVACY

At **Advanced Dentistry of Walnut Creek**, we understand that your health information is personal. We are committed to protecting your Protected Health Information (PHI) and complying with the Health Insurance Portability and Accountability Act (HIPAA). This notice explains how we may use and disclose your health information and describes your rights regarding your dental records.

HOW WE MAY USE YOUR INFORMATION

Treatment: We may use and share your information to:
• Diagnose dental conditions • Coordinate treatment • Prescribe medications
• Refer you to specialists • Communicate with laboratories

Payment: We may use your information to:
• Submit insurance claims • Obtain pre-authorizations • Bill for services • Collect outstanding balances

Health Care Operations: Your information may be used to:
• Improve patient care • Conduct quality reviews • Train employees • Perform audits • Maintain licensing compliance

Other Uses Required by Law: We may disclose information when required by law, including:
• Public health reporting • Child or elder abuse reporting • Court orders • Workers' compensation • National security
• Law enforcement requests

YOUR RIGHTS

As our patient, you have the right to: **Receive a Copy of This Notice** You may request another copy at any time.

Inspect Your Records: You may inspect and obtain copies of your dental records, subject to applicable law.

Request Corrections: If you believe information in your records is incorrect or incomplete, you may request an amendment.

Request Confidential Communications: You may ask us to contact you:
• At another address • At another phone number • Through another communication method

Request Restrictions: You may request restrictions on certain disclosures. While we are not required to agree to every request, we will comply when required by law.

Receive an Accounting of Disclosures: You may request a list of certain disclosures made by our office.

File a Complaint: If you believe your privacy rights have been violated, you may contact our Privacy Officer. You may also file a complaint with the U.S. Department of Health and Human Services. You will never be retaliated against for filing a complaint.

OUR RESPONSIBILITIES: We are required to: • Protect your health information • Provide this Notice • Follow this Notice • Notify you if a breach affecting your unsecured PHI occurs, as required by law

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Information

Patient Name

Date of Birth

Phone Number

Acknowledgment

I acknowledge that I have been offered or received a copy of this dental office's Notice of Privacy Practices.
I understand that this notice explains:
• How my Protected Health Information may be used • My rights under HIPAA • How to obtain additional copies • How to file a privacy complaint **Patient Initials** _____

Communication Preferences: Please contact me by:

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text Message ☐ Email Preferred Number:_____

Appointment Reminders: I authorize appointment reminders by:

☐ Phone ☐ Text ☐ Email ☐ Voicemail **Patient Initials** _____

Electronic Communication: I understand that email and text messages may not always be encrypted. I authorize electronic communication regarding:

☐ Appointments ☐ Treatment ☐ Billing ☐ Insurance **Patient Initials** _____

Patient Signature: Date

If signed by legal representative Name: Relationship:

Office Use Only ☐ Notice Provided ☐ Patient Declined Copy ☐ Unable to Obtain Signature

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION:

This form authorizes our office to share your protected health information with the individual(s) listed below. This authorization is voluntary.

Patient Information

Patient Name: Date of Birth

Phone

Authorized Person #1
Name

Relationship

Phone

May Receive Information Regarding:
☐ Appointments ☐ Treatment ☐ Treatment Plans ☐ X-rays ☐ Financial Information ☐ Insurance ☐ Billing ☐ Prescription
☐ All Dental Information

Authorized Person #2
Name

Relationship

Phone

May Receive Information Regarding
☐ Appointments ☐ Treatment ☐ Treatment Plans ☐ X-rays ☐ Financial Information ☐ Insurance ☐ Billing ☐ Prescriptions
☐ All Dental Information

Restrictions
Do NOT disclose the following information:

Expiration: This authorization expires:
☐ Upon written revocation ☐ One year from signature ☐ Other

Right to Revoke: I understand that:
• I may revoke this authorization at any time by submitting a written request.
• Revocation will not affect disclosures already made before my request was received.
• I may refuse to sign this authorization.
• My refusal will not affect my ability to receive treatment.

Signature
Patient Signature: Date:

Legal Representative (if applicable) Relationship