Notice Of Privacy Practices

Thomas S. Melanson, DDS
FAMILY DENTISTRY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.
EFFECTIVE DATE: 6/15/2015

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change In our privacy practices, we will change this Notice and make the new Notice available upon request.

We will post this notice and any revised Notice of Privacy Practices on our website. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the Information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations, For example.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Public Health Activities: We may use and disclose your health information for public health activities which generally include preventing or controlling disease, injury or disability; reporting adverse effects of medications or problems with products; enabling product recalls, repairs, replacements; notifying persons exposed to communicable disease or at risk for contracting or spreading a disease; or reporting abuse or neglect under certain circumstances.

Health Oversight Activities: We may use and disclose your health information to a health oversight agency for activities authorized by law, including audits, investigations, licensure, disciplinary actions, administrative proceedings or other activities for appropriate oversight of the health care system, government programs and compliance with laws.

Law Enforcement Purposes: We may use and disclose your health information for a law enforcement purpose to comply with a subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness or missing person; to respond to an official about a victim of a crime under limited circumstances; or to report a crime, location of the crime or victims or the identity, description or location of the person who committed the crime in an emergency circumstance.

Coroners and Medical Examiners: We may use and disclose your health information to a coroner or medical examiner for the purpose of identifying a deceased person.

National Security/Intelligence Activities. We may use and disclose your health information to authorized federal officials for the purpose of conducting lawful intelligence, counterintelligence and other national security activities.

Protection of President and Others: We may use and disclose your health information to authorized federal officials for the provision of protective services to the President or other authorized persons or foreign heads of state or to conduct authorized investigations.
Workers' Compensation: We may use and disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures.

In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that Is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reason¬able Inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Continue to Page 2 >

108 Mt. Carmel Rd.
Parkton, Maryland 21120
Thomas S. Melanson, DDS LLC
410-329-2118
info@thomasmelansondds.com

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Serious Threat or Health or Safety: We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Military and Veteran Activities: We may use and disclose your health information if you are a member of the armed forces or separated/discharged from military services as required by military command authorities or the Department of Veteran Affairs as may be applicable. Furthermore, we may use and disclose health information about foreign military personnel to the appropriate foreign military authorities.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards. or letters).

Clinical Photos: Photos may be used for insurance claims and, marketing, patient education, and case presentation. At no time will your name, identification, or other health information be published in print or over the World Wide Web without written consent.

PATIENT RIGHTS

Access: You have the right to inspect and copy your health information. We are entitled to charge you a reasonable fee related to the cost of copying your records. We may deny your request to inspect and copy your health information under certain circumstances. If you are denied access to your health information in limited circumstances, you may request that the denial be reviewed. Another licensed health care professional chosen by us will review your request and denial. We will comply with the outcome of the review.

Disclosure Accounting: You have the right to receive an accounting of disclosures of your health information other than to carry out treatment, payment, healthcare operations and certain other activities, for the last 6 years. If you request an accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request restrictions on the use and disclosure of your health information. We are not required to agree to these restriction if it is not feasible for us to do so or if we believe that it would negatively impact your care. If we do comply with your request, we may not use or disclose your health information in violation of such restriction except if you are in need of emergency treatment and the information is necessary for such treatment. Furthermore, if this restricted information is disclosed, we will request that the health care provider not further use or disclose the information.

Alternative Communication; You have the 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 location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing. and it must explain why the information should be amended.) We may deny your request if the health information that is the subject of the request: (a) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (b) is not part of the health information kept by or for us; (c) would not be available for you to inspect and copy; or (d) is accurate and complete.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive a paper copy of this Notice.

QUESTIONS AND CONCERNS

If you want more information about our privacy practices or have questions or concerns, please contact the Privacy Officer listed below.

If you are concerned that we may have violated your privacy rights, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. We will provide you with the contact information to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.
Privacy Officer: Thomas S Melanson DDS
Telephone: (410) 329-2118
E-Mail: Drtom@thomasmelansondds.com
Address108 Mt. Carmel Rd. Parkton, MD 21120

2146691

THOMAS S. MELANSON, DDS
FAMILY DENTISTRY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact their Compliance Officer at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name : ___________________________

Signature: ______________________________ **Date:**_______________________

Relationship to Patient (if not self): ______________________________

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, but was unable to do so as documented below.

Date	**Initials**	**Reason**

Office Policies

At this office, we take your health and our role in your health very seriously. We also believe that your optimal dental health requires a partnership between you and your dental care provider. Therefore, we strive to provide the highest quality of dental service to you. Please read and sign the following office policies.

Appointment Policy

Once an appointment is made, please remember this time has been reserved for you. All reminder calls and communications are done as a courtesy and you are responsible for keeping appointments that you have made. A minimum charge will be made for repeated failed or cancelled appointments without prior notification of 24 hours. ***We do not accept cancellations via our voice mail, e-mail, or website system. You must speak with a staff member directly.***

Financial Policy

Our practice is committed to providing the best treatment for our patients and we set our fees based on the quality of treatment we provide. The insurance policy is a contract between you and the insurance company. We do no t provide service passed on insurance coverage, but patient need. You are ultimately responsible for the fees on the account regardless of insurance coverage. Please be aware that by participating in your insurance program, we are providing service at a greatly reduced fee.

Full payment is due and payable at the time of service. We accept cash, check, Visa, MasterCard, American Express, Discover, and CareCredit

Insurance: It is our pleasure to assist you in maximizing your insurance benefits and, as a courtesy, we will file your claims for you. We will estimate your deductible and the portion not covered by your insurance, and this amount is due and payable at the time of service. As it is impossible for us to know the details of every insurance policy, our estimate may differ from the actual coverage, and your account will be adjusted accordingly when your claim is paid.

Out of Network Insurance: Please be aware that all services rendered are charged directly to the patient and that the patient is personally responsible for payment of those fees. We will gladly help prepare the necessary forms or reports to help you obtain your benefits from insurance companies upon receipt of full (or partial) payment of bill.

Any special arrangements must be discussed with and approved by Dr. Thomas Melanson prior to the start of treatment.

Delinquent accounts: Patients with delinquent accounts will be required to make full payment on the account prior to making appointments for additional treatment. A **late fee of $30** will be applied to all accounts overdue more than 90 days from the date of service. You are responsible for costs associated with the collection of a delinquent account including reasonable attorney fees and court costs. Dr. Melanson is authorized to disclose portions of the patient's dental record to the extent necessary to determine liability for payment and to obtain reimbursement. Furthermore, you may be dismissed from the practice.

Continue to Page 2 >

Office Policies

Furthermore:

You must provide our office with complete and accurate billing information prior to treatment, including current insurance card. If we cannot verify your insurance, you will be asked to make full payment.

You must know and understand the terms of your insurance coverage. If you have questions, please ask us.

You are responsible to Thomas S Melanson DDS LLC for all charges for dental treatment not covered by insurance, including co-payments, deductibles and fees for non-covered services. You are responsible for all fees not paid after 60 days from date of service, regardless of the status of your insurance claim. If claim is subsequently paid, you will be refunded the claim amount.

You authorize Thomas S Melanson DDS LLC to submit claims and you assign insurance benefits to Dr. Melanson including any or all insurance checks that are sent directly to you. Assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered as valid as an original.

If you have any questions about our financial policy or have any uncertainty regarding insurance coverage, please do not hesitate to ask.

I have read and understand the above policy and agree to comply with its terms.

Signed (patient or guarantor): ______________________________ date: ______________

Print name: ____

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name ______________________ Preferred name ____________ Birth date __________

If minor, parents' names ______________________ Home phone __________ Work phone __________

Mailing address ______________________ City ____________ State ______ Zip ________

Employer ______________________ Occupation ______________________

Spouse's name ____________________ Spouse's employer ____________________ ❑ Unmarried

Whom may we thank for referring you to our office? ______________________

Email: ______________________ Cell phone ______________________

❑ I prefer to be contacted by email

❑ I prefer to be contacted by text message

❑ Please only call or send mail notices

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: ______________ Dental Insurance Co. ______________ Group number __________

Insurance ID # ______________ Policy Holder ______________ Responsible Party ______________

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company ______________ Group number ______________

Spouse's birthday ______________ Social Security number ______________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other: ______________________

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other: ______________________
  ____

Women:

- ❑ May be pregnant
  Expected delivery date: __________
- ❑ Taking hormones or contraceptives

Name of your physician: ______________________

Do you have any disease, condition, or problem not listed above? ______________________

Please add anything else you would like us to know: ______________________

Signature of patient (or parent) ______________________ Date ______________