Please read carefully and if you have any questions, please contact us at 877-929-0030.

Dental Provider Notice of Privacy Practices

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.

This Notice is effective January 6, 2014

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 of Privacy Practices, our legal duties, and your rights concerning your health information described in this notice while it is in effect. We reserve the right to make changes in our privacy practices and terms of our 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. In the event that a change is made to the Notice, we will make the new Notice available upon request. We will promptly revise and distribute the Notice whenever there is a material change to the uses or disclosures, the individual's rights, our legal duties or other privacy practices stated in this Notice. 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 our Privacy Officer.

Uses and Disclosure of Health Information

We may use and disclose your identifying health information for treatment, payment, and healthcare operations; some examples may include:

Treatment: We may disclose your health information to a physician or other healthcare provider providing treatment to you. We may use and disclose medical information about you to provide, coordinate or manage your healthcare and related services. This may include communicating with other healthcare providers regarding your treatment and coordinating and managing your healthcare with others.

Payment: We may disclose your health information to your insurance carrier(s), personnel of your respective nursing/care facility, powers of attorney, responsible parties or any person(s) responsible for your finances in order to obtain payment for dental services provided to you.

Healthcare Operations: We may use or disclose your health information in connection with our dental operations to the administrative entity coordinating the providing of your dental care. Dental operations include: quality assessment and improvement activities, reviewing the competence or qualification or evaluation of healthcare professionals, and providers to oversee, supervise, or dictate the professional activities of duly licensed dental professionals. We may also disclose your health information to business associates who have signed a HIPAA business associate agreement.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of a family member, your personal representative or other person(s) responsible for your care, of your location, your general condition, or death. If you are present, prior to use and disclosure of your health, we will provide you with an opportunity to object to such uses and 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 experiences with common practices to make reasonable inferences of your best interest in allowing a person to obtain dental supplies, x-rays, or other similar forms for health information.

Non-Disclosure without Authorization: The following uses and disclosures of medical information about you will only be made with your authorization (signed permission): for marketing purposes, the sale of medical information about you, psychotherapy notes (if we maintain psychotherapy notes) or any other use not described in this Notice.

Required by Law: We may use or disclose your 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 the 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, well-being, safety, or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Force personal under certain circumstances. We may disclose to federal officials health information required for lawful intelligence, counterintelligence, and

other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Your Authorization: In addition to the examples above, you may give us written authorization to use your health information to disclose it to anyone for any purpose. If you provide an authorization, you may revoke this in writing at any time. Your retraction will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you provide us with written authorization, we cannot use or disclose your health information for any reason except those reasons listed in this Notice.

Individual Rights: You have the right to view or obtain copies of your health information with limited exceptions (you must make a request in writing to obtain access to your health information). You may obtain a form to request access by using contact information listed at the end of this Notice. We may charge you a reasonable cost-based fee for expenses such as copies and administrative personnel time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you for administrative personnel time to locate and copy your health information, and postage if you request to have copies mailed to you. If you request an alternative format, we may charge you a cost-based fee for providing your health information in the request format, if approved.

a. 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 with these restrictions, but if we do we will abide by our agreement (except in an emergency).
b. 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 payment will be handled under alternative means or location you request.
c. 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 under certain circumstances.
d. You have the right to receive an accounting of disclosures of protected health information for the previous six years.

Right of Notification if a Breach of your Medical Information Occurs: You have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and that information is unsecured (not encrypted), we will notify you promptly.

Questions and/or Grievances

You may send questions to our office directly or to the Secretary of Health and Human Services. If you believe your privacy rights have been violated, you may file a complaint directly with our Privacy Officer or with the Secretary of Health and Human Services. You may request further information about the complaint process by notifying our Privacy Officer at the address below. We will not react against you in any way for filing a complaint.

Attention to: Privacy Officer
19820 N. 7th Street, Suite 290
Phoenix, AZ 85024
P: 1-877-929-0030
F: 1-877-929-0031

Please read carefully and if you have any questions, please contact us at 877-929-0030.

Dental Provider

Patient Acknowledgement: Receipt of Privacy Notice

I, _____, hereby affirm that I have received a copy of the Notice of Privacy Practices from the dental provider who provides my dental care under this program. Under federal law, I am entitled to receive a copy of this Notice from my dental provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the Notice, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the Notice of Privacy Practices from my dental provider, whether I sign this Acknowledgement or not.

Patient Name: _____

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority (if applicable)

_____
Facility of Patient

Declination:

_____
Reason for Declination

_____
Name of Staff Member who Received Declination Notice

_____
Signature of Staff Member

_____
Date

_____
Facility of Patient

19820 North 7th Street, Suite 290
Phoenix, AZ 85024

Please read carefully and if you have any questions, please contact us at 877-929-0030.

Dental Provider

General Consent for Dental Treatment

I consent to a comprehensive clinical examination and the following:

1. I recognize the need for my dental provider to exercise his or her professional judgment on my behalf and I therefore authorize my dental provider to select treatment options based on my dental and physical condition.
2. During the course of treatment, I may undergo procedures in all phases of dentistry including, but not limited to, periodontics (gum treatment and/or surgery), oral surgery, removable prosthetics, restorative dentistry (fillings), oral pathology and radiography.
3. No guarantees can be made in regard to treatment outcomes, restoration longevity or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
4. Some of the more commonly known risks and complications of treatment may include:
   - Pain, swelling and discomfort after treatment
   - Infection and the need for medications, follow up procedures or other treatment
   - Temporary or, on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums or tongue along with possible loss of taste
   - Damage to adjacent teeth, restoration or gum tissues
   - Possible deterioration of your condition which may result in tooth loss
   - Possible injury to the jaw joint or bone and related structures including the sinus cavity requiring follow up care and/or treatment.
   - Allergic reactions to anesthetic or medication
5. My treatment plan may change at any time and I will approach my dental care with open communication between myself, my dental provider and my facility.
6. My dental care is being provided in a nursing home setting or other non-dental office location. Based on this, I am aware that my results may differ slightly from those in a fixed dental office because of a lack of patient mobility and other unforeseen and uncontrollable circumstances.
7. My dental provider will provide dental care in conjunction with the recommendation of my medical physician when necessary.

I have read and understand the above and give my consent to have recommended dental treatment.

Patient Name: _____

Patient Signature or Responsible Party: _____

Date: _____

Facility Name: _____