NOTICE OF PRIVACY PRACTICES

THIS NOTICE DECRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS HEALTH INFORMATION.

PLEASE REVIEW IT CAREFULLY THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability, Act (HIPPA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes thast are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

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 make 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.

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 dentist, physician, and other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to a physician or other healthcare provider providing treatment 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 health care professionals, evaluating practitioners and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorizations: In addition to our use of your health information for treatment, payment, or healthcare operations, 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 disclosure permitted by your authorization white 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 the 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, 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 you 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 us our professional judgment and our experience with common practice to make reasonable 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.

Marketing Health-Related Services: We will not use your health information for marking communications.

Required by Law: We may use or disclose your health information for marketing communications.

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 the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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

Sign-In Sheet: We may ask that you sign in writing at the receptionist desk a "Sign-In" sheet when you arrive for your appointment.

PATIENT RIGHTS

Access: You have the right to look at or get 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 practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying cost, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which, we or our business associate disclose your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six (6) years, but before April 14, 2003. If you request this accounting more than once in a 12-month period, we reserve the right to charge you a reasonable, cost-based fee for responding to these additional request.

Restriction: 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).

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 under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address 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.

Contact Officers: Kim Wood or Arnetta Clark
857 S. Auto Mall Road
Bloomington, IN 47401

ACKNOWLEDGEMENT OR RECEIPT OF PRIVACY PRACTICES

I hereby acknowledge that I have had the opportunity to review or have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature______________________________________**Date**__________________________

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I,____,Date of Birth:____________________, request that the following be followed for the disclosure of my Protected Health Information. Protected Health Information would include your name, diagnosis(es), test results, dates of service.

PLEASE CHECK ALL THAT APPLY

☐ **You may disclose information to my family members and or non-family members. Please list name, phone number and relationship.**

NAME	Phone Number	Relationship

☐ **You may leave Protected Health Information on my answering machine/voicemail.**

Phone Number: ____

☐ **Other:** ____

______________________________ _________________________
Patient's Printed Name **Social Security Number**

______________________________ _________________________
Patient's Signature(or Guardian, if minor) **Date**

______________________________ _________________________
Witness (optional) **Date**

857 Auto Mall Road, Bloomington, IN 47401 Phone (812)339-4400

Thomas W. Watkins DDS, LLC
857 Auto Mall Road
Bloomington, IN 47401
812-339-4400

FINANCIAL ARRANGEMENTS

Name____Date_______________

Listing of all dependents for whom you are financially responsible

____

____

Insurance Policy

1. As a service to our patients, we will file insurance claims on their behalf and will respond in a timely manner to request for additional information made by the carrier.

2. We will accept assignment of insurance benefits as payment for services rendered with any amount not expected to be covered by insurance due on the day of service. We will allow a maximum of 90 days for the receipt of insurance payment, however: if payment is not received in this time, the the patient will become responsible for payment of the account. Please understand that insurance coverage is a relationship between the insurance company and the insured (the patient). The patient is the customer of the insurance and thus has the leverage in getting claims paid in a timely manner. As the provider, we have no recourse against insurance companies that are habitually delinquent and will reserve the right to refuse to accept assignment from such companies.

3. Usual and customary determinations made by the insurance company indicate the level of coverage purchased by the subscriber and are not necessarily indicative of fees charges in this office.

4. Any balance due after this insurance claim has been paid will be billed to the patient and is due within 30 days. Any resulting overpayment will be refunded to the patient in a timely manner.

Payment Arrangements

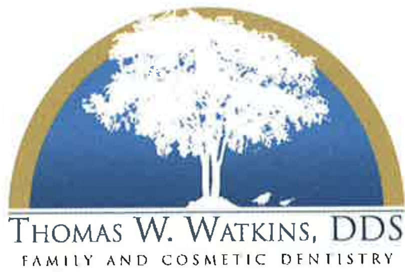
1. All monthly statements are due and payable upon receipt unless prior financial arrangements have been made. We accept cash, checks, Visa, MasterCard and Discover cards.

2. We reserve the right to charge interest on past due account balances. Interest will be charged at an annual rate of 18% (1.5% per month). If collection procedures are required, the patient is responsible for all collection & attorney fees. A minimum $25.00 fee will be charged for all returned checks.

3. We reserve the right to charge for failed appointments (minimum of $30.00). An appointment is considered "failed" if it is canceled with less than 24 hours notice, or if a patient misses an appointment with no notification. We ask that as a courtesy, at least two days notice be given on all appointments that must be rearranged.

I have read the above financial policy and agree to the terms outlined. I hereby authorize payment to Dr. Thomas W. Watkins DDS, LLC of the group insurance benefits otherwise payable to me. Additionally, I authorize the release of any information relating to dental claims submitted by Dr. Watkins. I understand that I am responsible for all fees for dental treatment regardless of payment by my insurance company and I fully understand that an appointment canceled with less than 24 hours notice is subject to a failed appointment charge as noted.

SIGNATURE_________________________________**DATE**________________________



HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)

CONSENT FOR RELEASE OF DENTAL X-RAYS AND/OR DENTAL RECORDS

PATIENT GIVING CONSENT TO RELEASE DENTAL X-RAYS AND OR DENTAL RECORDS

FROM: **THOMAS W. WATKINS DDS, LLC**
857 AUTO MALL ROAD
BLOOMINGTON, IN 47401

RELEASE TO: ______________________________
(DOCTOR'S OFFICE NAME

DOCTOR'S ADDRESS: ______________________________

____

PATIENT'S NAME: ______________________________

ADDRESS: ______________________________

____

TELEPHONE NUMBER: ______________________________

SOCIAL SECURITY NUMBER: ______________________________

☐ **RELEASED RECORDS TO PATIENT**

PATIENT'S SIGNATURE: __________________________ **DATE:** ______________