Notice of Privacy Practices for Protected Health Information

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!**
With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights
The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:
Request a restriction on certain uses and disclosures of your health information by delivering the request in
writing to our office. We are not required to grant the request but we will comply with any request granted;
Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full we must comply with this request;
Request that you be allowed to inspect and copy your health record and billing record you may exercise this right by delivering the request in writing to our office;
Appeal a denial of access to your protected health information except in certain circumstances;
Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,Elect to opt out of receiving further fundraising communications from the office/hospital Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.
If you want to exercise any of the above rights, please contact [**Francis Obando 305-532-9114**], in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities
The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint
If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact [**Francis Obando 305-532-9114**].
Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to [list internal staff member.] You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is [**1315 Alton Road MB, FL / Info@precioussmiles.com**.]

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)
We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website
If we maintain a website that provides information about our entity, this Notice will be on the website. Effective Date: [**September 30, 2013**]

hereby acknowledge that I 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.

OPTIONAL/ADDITIONAL Uses and Disclosures
The following are segments of the Notice of Privacy Practices that may not be used by the general OMS practice. If your Notice of Privacy would need to incorporate any of these items, we have provided model language. An example would be: If your practice participates with drug research, then you would need to include the first item listed below in your Notice of Privacy Practices.

Research
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief
We may use and disclose your protected health information to assist in disaster relief efforts.

Funeral Directors/Coroners
We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

Organ Procurement Organizations
Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing
We may contact you to provide you with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you.

Fund Raising
We may contact you as part of a fund raising effort.

For Specialized Governmental Functions
We may disclose your protected health information for specialized government functions as authorized by law,
such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Consent for Dental Treatment

I understand that by signing this consent I am in no way obligated to any treatment. I also acknowledge that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination - for example, root canal therapy following routine restorative procedures, additional fillings from decay which was not visible on x-rays. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

RESTORATIVE DENTISTRY - CROWNS, BRIDGES, VENEERS, OPERATIVE (Fillings)

I understand, that unlike most other tissues in the human body, teeth do not have the ability to regenerate, thus any time a tooth is touched for any type of restoration, regardless of the size or the circumstance, there is always a risk of possible sensitivity, the need for a Root Canal, or even extractions.

This may occur even if the tooth was not sensitive prior to any treatment! I may experience sensitivity when chewing, eating or drinking anything hot or cold. The tooth may even be sensitive without apparent cause. The bite may need adjustment, or the nerve may be so severely traumatized that root canal therapy or even extraction may be necessary. Any loss of tooth structure may necessitate the need of a crown, or a root canal, or even extraction in the future. I understand that I will be financially responsible for any additional treatment which may be required if any of the aforementioned complications arise; such as having a root canal, extraction, or having treatment continued with a specialist. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which come off easily, and that I must be careful to ensure that they are kept on until the final crown is delivered. I realize the final opportunity to make changes (shape of, fit, size and color) will be before cementation. It is also my responsibility to return for definitive cementation within 30 days from tooth impression. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be additional charges for remakes due to my delaying final cementation. I understand that porcelain/ceramic, and filling materials may fracture and that I will be responsible to pay for replacement.

I understand that I am responsible for ALL Dental Laboratory Fees associated with, but not limited to: Crown/Bridge/Veneers/Temporaries/ Wax-Up (work that I may require an outside laboratory to fabricate for me) I understand that NO Dental Restoration or Dental Prosthesis is permanent; most restorations need to eventually be replaced or re-restored sometime in the future. This need to re-do work is influenced by my oral habits, diet, oral hygiene, and maintaining regular bi-annual office visits for routine x-rays, and cleanings.

Dr. Isidoros Mereos guarantees his work with a 3 year warrantee if patient is complaint for their routine dental cleanings as recommended. Decay and periodontal disease must be eradicated for a period of time before the reconstruction. This health must continue to be maintained after the reconstruction or the entire treatment could be compromised. Since Major and Restorative treatment and full-mouth reconstructions involve so many different parts of the mouth, neglecting just one part of oral health maintenance could have implications on the entire treatment. I am aware if I miss any of my 4-6 month cleanings and/or routine exams, this will VOID all warrantees on treatment and will be my responsibility.

I understand that care must be exercised in chewing on filled teeth, especially during the first 24 hours to avoid stress. I understand that a more extensive restorative procedure than originally diagnosed may be required due to additional or extensive decay. I understand that significant sensitivity is a common after-effect of a newly placed filling.

I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions such as redness and swelling tissue, pain, itching, vomiting and/or anaphylactic shock.

I realize that it is mandatory that I give as accurate and complete a medical and personal history as possible, follow any and all instructions as directed, and permit prescribed diagnostic procedures.

I consent that photographs may be taken of me, under the following conditions:

1. The photographs may be taken only with the consent of my dentist and under such conditions and at such times as may be approved by him.
2. The photographs may be taken by my dentist or by a photographer approved by my dentist.
3. The photographs shall be used for dental records and if in the judgment of my dentist, dental research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which he may deem proper in the interest of dental education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name.
4. The aforementioned photographs may be modified or retouched in any way that my dentist, at his discretion, may consider desirable.

X______________________________________

Patient Signature