The Tooth Fairy

Notice of Privacy Policies (HIPAA)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please read it carefully. The privacy of your health information is important to us.

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's in effect. This notice takes effect 4/14/2003 and will remain in effect until we replace it. 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. Before we make a significant change in our privacy practice, 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 for treatment, payment and health care operations
**Treatment*: We may use or disclose health information to a physician, dentist, or other health care provider providing treatment to you.
**Payment*: We may use and disclose your health information to obtain payment for services we provide you.
**Health care operations*: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence of qualifications of health care professionals, evaluating practitioner and provider performance.

Your authorization: In addition to our use of your health information for treatment, payment of health care 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 authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosure 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 the following.
**To your family/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 health care or with payment for your health care, 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 of disclosure of your health information, we will provide you with an opportunity to object to such uses of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using 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/dental supplies, x-rays, or other similar forms of health information.
**Marketing health related service*s: 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.
**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 of others.
**National security*: We may disclose to military authorities the health information of Armed Force personnel under certain circumstances. We may disclose, to authorized federal officials, health information required for lawful intelligence, counter intelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.
**Appointment reminders*: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, messages, text messages, postcards, emails, or letters).

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 practically do so. (You must make a request in writing to obtain access to your health information.) You may obtain a form to request access by using the contract information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff 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 will charge you $5.00 for each page, 10.00 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. 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.
**Disclosing accounting*: You have a right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, health care-operations and certain other activities for the last six years. If you request this 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 that we place additional restrictions on our use or disclosure of our 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 location. 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 the alternative means for the 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 website or by electronic mail (e-mail), you are entitled to receive this notice in written form.

Questions and complaints:
Please contact us if you have questions or concerns. 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 to have us communicate with you by alternative means or an alternative location, 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 US Department of Health and Human Services. We will provide you with their address to file your complaint upon request. We will not retaliate in any way if you choose to file a complaint with us or the US Department of Health and Human Services.

Contact Officer: Amy Telephone: 785-266-4412 Fax: 785-266-2208 Address: 1230 SW Harvey St. Topeka, KS 66604

Acknowledgement of Privacy Practices (HIPAA)

Patient Name: _____ DOB: _____ Date: _____

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices (HIPAA). I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

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Patient, Parent, or Guardian Signature