STATEMENT OF PRIVACY PRACTICES

PORT ORCHARD DENTAL EXCELLENCE

Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTHCARE INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTHCARE INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI.

YOUR RIGHTS AS OUR PATIENT

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

Port Orchard Dental Excellence
700 Prospect St, Ste 100 Port Orchard, Washington 98366 | 360-876-3171
I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Port Orchard Dental Excellence. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Port Orchard Dental Excellence reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

**ADDITIONAL DISCLOSURE AUTHORIZATION**

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

<table>
<thead>
<tr>
<th>Spouse only</th>
<th>□ YES □ NO</th>
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</thead>
<tbody>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td>Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)</td>
<td>□ YES □ NO</td>
</tr>
<tr>
<td>Any Member of my extended family: (i.e. Parents, Grandchildren)</td>
<td>□ YES □ NO</td>
</tr>
<tr>
<td>Other:</td>
<td>□ YES □ NO</td>
</tr>
</tbody>
</table>

Name of patient (please print):

Patient signature:

Patient’s personal representative: (Please Print):

Personal Rep’s signature:

Representative’s Phone Number: Date:

**OFFICE USE ONLY BELOW THIS LINE**

**Acknowledgement Not Obtained**

<table>
<thead>
<tr>
<th>Provided Prior to Treatment?</th>
<th>□ YES □ NO</th>
<th>Date Statement Provided:</th>
</tr>
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<tbody>
<tr>
<td>□</td>
<td></td>
<td>Needed more time to review Statement</td>
</tr>
<tr>
<td>□</td>
<td></td>
<td>Wanted to consult another person before signing</td>
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<tr>
<td>□</td>
<td></td>
<td>Physically unable to sign</td>
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<tr>
<td>□</td>
<td></td>
<td>No reason offered</td>
</tr>
<tr>
<td>□</td>
<td></td>
<td>Other:</td>
</tr>
</tbody>
</table>

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700 Prospect St, Ste 100 Port Orchard, Washington 98366 | 360-876-3171
Office Policy

In order to provide you and your family with the highest quality in dental care we ask that you please comply with our office policy as described below:

I understand that when appointments are made, time is set aside for me with the doctor and dental staff. I agree to give 24 hours’ notice (48 hours’ is preferred) if I am unable to make it to or I need to reschedule an appointment. I also understand that if I fail to give notice for a broken appointment I will be subject to a $100 per hour broken appointment fee.

Although services may be covered by my insurance, I the insured understand that I am fully responsible for my account. Coverage and benefits are a contract between myself and the insurance company. Any billing to the insurance company is only done as a courtesy by my dental office.

Regardless of the insurance coverage, I am responsible for payment on my account and, although the office staff will gladly assist me with my insurance, I am also responsible to check with my insurance company on any problems with coverage or payments.

All accounts are subject to a 1.5% per month finance charge on the unpaid balance after 60 days. I will also be responsible for any collection costs and attorney fees in the event of non-payment.

If at any time I am unhappy in regards to treatment received in this office I agree to notify the office in a timely manner so that the doctor and/or staff may have a chance to rectify my concerns if they are able to.

I understand that violation of this office policy could lead to termination of my relationship with Port Orchard Dental Excellence.

I also agree to waive my right of confidentiality for collection purposes only.

I have read the aforementioned policy and understand and agree to these terms.

Signed: ___________________________ Date: ___________________________