NOTICE OF PRIVACY PRACTICES

Effective date of this notice: July 22, 2019

1. **LEGAL OBLIGATIONS OF LAKESHORE PEDIATRIC DENTISTRY, PLLC (LPD)**

We are required by law to maintain the privacy of your protected health information (PHI). This includes information that can be used to identify you that we have created or received about your past, present or future health conditions, the provisions of health care for you or the payment of this health care.

We are required by law to provide you with a Notice of Privacy Practices (NPP) which describes our legal duties and privacy practices with respect to PHI. This Notice will tell you about the ways in which we may use and disclose PHI about you. It also describes your rights and our obligations regarding the use and disclosure of your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this NPP. We are required to post the NPP within our facility and website and we are required to abide by the terms of the NPP that are currently in effect. Please note, however, that special privacy practices apply to HIV/AIDS related information, alcohol and substance abuse treatment information, mental health information and genetic information, which is not set forth in this Notice. Uses and disclosures for these purposes reflect other more stringent, applicable laws. For more information, please contact the office. We reserve the right to change the terms of the NPP and our privacy policies at any time. Any changes made will apply to the PHI we already have about you as well as any information we create or receive in the future. We will promptly post the revised NPP, with a new effective date. Upon your request, a copy of the revised NPP will be made available to you.

2. **HOW LPD MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)**

Uses and Disclosure Relating to Treatment, Payment or Health Care Operations. The following categories describe different ways that we may use or disclose your PHI. Examples are provided where appropriate, although it is impossible to list every use and disclosure in each category.

Treatment: We will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes coordination or management of your health care with another physician. We will also disclose PHI to other physicians who may be treating you. For example, to a physician to whom you have been referred to ensure that he/she has the necessary information to diagnose or treat you.

Payment: We may use and disclose PHI about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company or third party. For example, we may need to disclose your PHI to a health plan in order for the health plan to pay for the services rendered to you. We may also tell your health plan about a treatment or procedures you are going to receive in order to obtain prior approval or determine whether your health plan will cover the services. We may disclose PHI to another covered entity or health care provider to assist them in their payment activities.

Health Care Operations: We may use and disclose PHI about you for practice plan operations. The uses and disclosures are necessary to run our practice plan in an efficient manner and ensure that all patients receive quality care. For example, medical records and PHI may be used in the evaluation of health care services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing. We may also disclose PHI about you to medical students and residents for review and learning purposes. We may disclose PHI to another covered entity to assist in their healthcare operations as long as you had a relationship with the covered entity and the PHI relates to the relationship. The covered entity may only use your PHI to conduct quality assessment and improvement activities; review and evaluate the competence or qualifications of its health care professionals; and to detect healthcare fraud and abuse or compliance.

To the extent we are required to disclose your PHI to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations, we will have a written contract to ensure that our business associates also protect the privacy of your PHI.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care. For example, we may provide a written or telephone reminder that your next appointment is coming up. Written notice may be sent in the form of a postcard including your name as well as the date and time of your appointment.

Other Uses and Disclosures that Require Your Prior Written Authorizations.

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described in this NPP. If you choose to sign an authorization to disclose your PHI, you may revoke such authorization in writing, at any time, except to the extent that action has been taken in reliance on the use and disclosure indicated in the authorization.

Other Uses and Disclosures Where You Have the Opportunity to Agree or Object.

Disclosure to Family, Friends or Others (Individuals Involved in Your Care or Payment of Your Care): We may release PHI about you to a friend or family member who is involved in your medical care or the payment of your health care, unless you object in whole or part. If you are unable to agree or object to such disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Uses and Disclosures that May be Made Without Your Consent, Authorization or Opportunity to Object.

We may use and disclose your PHI without your consent or authorization for the following reasons:
Required by Law: We will disclose PHI about you when required to do so by federal, state or local law and the use and disclosure complies with and is limited to the relevant requirements of such law.
For Public Health Activities: We will report information about births and deaths; to prevent or control various diseases; to report child abuse and neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; or to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease. All such disclosures will be made in accordance with the requirements of federal, state or local law.
About Victims of Abuse, Neglect or Domestic Violence: We may release your PHI to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence.
For Health Oversight Activities: We may disclose PHI about you to a health oversight agency for activities authorized by law. The health oversight activities include, for example, audits, investigations, inspection and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
Lawsuits and Disputes: We may disclose your PHI if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. *For Law Enforcement Purposes:* We may release your PHI if asked to do so by a law enforcement official for any of the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's consent; about a death we believe may be the result of criminal conduct; about criminal conduct that occurred on our property; and in emergency circumstances to report a crime, the location of a crime or victims; or the identity, description or location of the person who committed the crime.
For Coroners, Medical Examiners and Funeral Directors: We may release PHI to a coroner or medical examiner when authorized by law. This may be necessary, for example, to determine the cause of death. We may also release PHI to funeral directors as necessary to carry out their duties.
For Organ or Tissue Donation Purposes: If you are an organ donor, we may release PHI to organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.
To Avert a Serious Threat to Health or Safety: In order to avoid a serious threat to the health and safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
Specialized Government Functions: We may disclose PHI for national security purposes to authorized federal officials authorized by law. In addition, we may disclose PHI to authorized federal officials so they may provide protection to the President, other authorized personnel or foreign heads of state or to conduct special investigations.
Military and Veteran Activities: If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.
Inmates and Correctional Institutions: If you are an inmate or you are detained by a law enforcement officer, we may disclose your PHI to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing PHI that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.
Worker's Compensation: We may release PHI about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
Emergency Situations: We may use or disclose your PHI if you need emergency treatment and we are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.
Communication Barriers: We may use or disclose your PHI if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

Individual Rights

The Right to Request Restrictions on Certain Uses and Disclosures of PHI.

You have the right to request restriction or limitation on the PHI we use or disclose about you for treatment, payment and health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We will consider your request for restrictions, but we are not legally required to accept it. However, we must agree to your request to restrict disclosures to a health plan if the disclosure is for the purpose of obtaining payment for your treatment or other health care operations, is not otherwise required by law, and you have paid us in full for the treatment or service. If we accept your request, we will comply with your request except in emergency circumstances. To request restrictions, you must make your request in writing to the contact person listed in Section 4. This request must include 1. What information you want to limit; 2. Whether you want to limit our use, disclose or both; and 3. To whom you want the limits to apply, for example, disclosures to a spouse.

The Right to Receive Confidential Communications of PHI.

You have the right that we communicate with you about all matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. You do not have to state a reason for your request. We will accommodate all reasonable requests. Your request must be in writing and specify how or where you wish to be contacted. To make a request, please contact the office.

The Right to Inspect and Copy PHI.

You have the right to access (inspect and/or copy) medical information that may be used to make a decision about your care. Usually this includes medical and billing records, but does not include psychotherapy notes that are maintained in separate files or information compiled in anticipation of a civil, criminal or administrative action or proceeding. If the requested medical information is maintained electronically and you request an electronic copy, we will provide access in an electronic format, if it is readily producible, or if not, in a readable electronic form and format mutually agreed upon.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request to the office. We will respond to your request within 10 days. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. In addition, instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to any associated costs in advance. In certain situations, we may deny your request. If we do, we will tell you in writing our reasons for the denial, explain your right to have the denial reviewed and the process by which you may complain to UPD or Secretary of the Department of Health and Human Services (See Section 3.). If you request that the denial be reviewed, another licensed health care professional chosen by UPD will review your request and the denial. The person conducting the review will not be the person who denied your initial request. We will comply with the outcome of the review.

The Right to Amend PHI.

If you feel that medical information about you is incorrect or incomplete, you may request that we amend the information. You have the right to request an amendment for as long as the information is kept with LPD.

You must provide the request for an amendment in writing and include a reason to support the request. We may deny your request if you ask us to amend information that 1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment; 2. Is not part of the medical information kept by or for UPD; 3. Is not part of the information which you would be permitted to inspect or copy; or 4. Is accurate and complete. Our written denial will state the reasons for denial, explain your right to file a written statement of disagreement with the denial and the process by which you may complain to LPD or Secretary of the Department of Health and Human Services (See Section 3.) This statement must be submitted in writing to the contact person listed in Section 4. We have the right to submit a rebuttal statement. If you do file such a statement, all information regarding you request for an amendment will be attached to your record and sent with future disclosures of you PHI. If you do not file such a statement, you must request that all future disclosures of your PHI contain your request and our denial. If we approve your request, we will make the change to your PHI, tell you that we have done so and tell others that need to know about the changes to your PHI.

The Right to Receive an Accounting of Disclosure of PHI.

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your PHI, but will not include uses of disclosures that you have already been informed of in this NPP, such as those made for treatment, payment or health care operations, directly to you, or to your family or pursuant to a signed authorization.

To request this list or accounting disclosures, please submit your request in writing to the person listed in Section 4. Your request must state the time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will respond to your request within 60 days. The list you receive will include 1. Date of disclosure; 2. To whom the PHI was disclosed, including his/her address, if known; and 3. A brief description of the PHI disclosed and the reason for the disclosure.

The Right of the Individual to Receive a Paper Copy of this NPP.

You have the right to a paper copy of this NPP. You may request a copy of this NPP at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. To obtain a paper copy of this NPP, please contact the office.

Breach Notification.

We must notify you if we have reason to believe your unsecured medical information has been compromised due to unauthorized acquisition, access, use or disclosure.

3. **COMPLAINTS**
If you think your privacy rights have been violated or you disagree with a decision we made about access to your PHI, you may file a complaint with LPD by contacting the person listed in Section 4. You may also send a written complaint to the Secretary of the Department of Health and Human Services of the Office of the Secretary, Department of Health and Human Services, 200 Independent Avenue S.W., Washington D.C. 20201. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

4. **CONTACT**
If you have any questions about this NPP, our privacy practices, or any other office matters, please contact us at (518) 282-5519.

Lakeshore
PEDIATRIC DENTISTRY

DEMOGRAPHIC INFORMATION

COMPLETED FORM GOES TO CLINICAL STAFF

Please fill out this form completely in ink.

New Patients: Please share with us how you were referred:_____ Today's date: _____
Name of person completing this form:_____ Relationship:_____

Patient Information			
Last Name:	First Name:		Middle Initial:
Birthdate: / /	Social Security Number:		Sex: ☐ Male ☐ Female
Patient's Home Address:			
City:	State:	Zip:	Home #: Cell #:
Financially Responsible Party - Primary Parent / Guardian			
Last Name:	First Name:		Middle Initial:
Relationship: ☐ Mother ☐ Father ☐ Legal custodian – Relationship:			☐ Custody Paperwork Provided
Primary Language:			
Social Security Number (**required**):		Birthdate: / /	
Address (if different from above):			
City:	State:	Zip:	Home #: Cell #:
Secondary Parent / Guardian			
Last Name:	First Name:		Middle Initial:
Relationship: ☐ Mother ☐ Father ☐ Legal custodian – Relationship:			☐ Custody Paperwork Provided
Social Security Number (**required**):		Birthdate: / /	
Address (if different from above):			
City:	State:	Zip:	Home #: Cell #:
Emergency Contact Information			
Name:	Phone Number:		Relationship:

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IF THE PATIENT HAS DENTAL INSURANCE THIS SECTION MUST BE FILLED OUT	
Primary Dental Insurance	
Insurance Company:	
Insured Person Name:	Relationship to Patient:
Insurance ID #:	Birthdate: / /
Social Security Number:	Employer:
Insurance Company Phone Number:	Plan Group #:
Secondary Dental Insurance	
Insurance Company:	
Insured Person Name:	Relationship to Patient:
Insurance ID #:	Birthdate: / /
Social Security Number:	Employer:
Insurance Company Phone Number:	Plan Group #:

PATIENT FINANCIAL & INSURANCE AGREEMENT: I have received, reviewed and understand the Lakeshore Pediatric Dentistry, PLLC Patient Financial & Insurance Agreement and I agree to and accept the terms and conditions stated therein. I may contact Lakeshore Pediatric Dentistry, PLLC at any time to obtain a current copy of the Patient Financial & Insurance Agreement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received, reviewed and understand the HIPAA Notice of Privacy practices from time to time. I may contact Lakeshore Pediatric Dentistry, PLLC at any time to obtain a current copy of their Notice of Privacy Practices by contacting (518) 282-5519, info@lakeshorepediatricdentistry.com, 2993 Main Street Suite #2, Peru, NY 12972.

DISCLOSURE TO FAMILY OR FRIENDS INVOLVED IN MY CARE: Subject to the HIPAA Notice of Privacy Practices, I understand that I may limit the disclosure of heath information to family members, or other close personal friends by notifying a member of the staff assigned to care for me.

I have read all the above statements and accept the terms and conditions as stated. To the best of my knowledge the questions on this form have been. Accurately answered and information given regarding my insurance is accurate and current. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in patient information, medical status, insurance coverage, and familial status.

(Signature of Responsible Party):

_____

HEALTH INFORMATION

Please fill out this form completely in ink

Today's date: _____

Name of person completing this form:_____ Relationship:_____

Patient Information

Last Name:	First Name:	Birthdate: / /

Dental History

Previous Dentist:	Date of last visit:	Phone:

Address:	City:	State:	Zip:

Were x-rays taken?	☐ No ☐ Yes	Please explain:
Has this patient had difficulty with previous dental visits?	☐ No ☐ Yes	Please explain:
Are you aware of any problems with this patient's mouth or teeth?	☐ No ☐ Yes	Please explain:
Has this patient ever pre-medicated for dental treatment?	☐ No ☐ Yes	Please explain:
Has this patient injured head, mouth, or teeth?	☐ No ☐ Yes	Please explain:
Has this patient ever developed any condition including bleeding, drug, anesthesia reaction, or rash requiring special treatment after a dental visit?	☐ No ☐ Yes	Please explain:

For Patients Under 18 Only

Does your child take fluoride supplements?	☐ No	☐ Yes
Is your child's water fluoridated?	☐ No	☐ Yes
Does your child suck his/her thumb/finger?	☐ No	☐ Yes
Does your child suck/bite his/her lip?	☐ No	☐ Yes
Does your child bite/chew his/her nails?	☐ No	☐ Yes
Does your child chew hard objects?	☐ No	☐ Yes
Does your child grind his/her teeth?	☐ No	☐ Yes

Physician & Pharmacy Information

Pharmacy Name:	Address:	Phone Number:

Physician Name:	Phone Number:	Date of last visit:

Previous hospitalizations/surgeries/serious illnesses and when:

Continued on next side

Medical History (Confidential)

Is this patient *taking* any medications?	☐ No ☐ Yes	Please list:
Is this patient *allergic* to any medications?	☐ No ☐ Yes	Please list:
Is this patient pregnant?	☐ No ☐ Yes	Trimester:
Has this patient had a blood transfusion?	☐ No ☐ Yes	Please list:
Are immunizations up to date?	☐ No ☐ Yes	Please list:

Respiratory Diseases/Lung Disorders			Blood Disorders			Infectious Diseases		
Asthma	☐ No	☐ Yes	Anemia	☐ No	☐ Yes	HIV/AIDS	☐ No	☐ Yes
Difficulty Breathing	☐ No	☐ Yes	Excessive Bleeding	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes
COPD	☐ No	☐ Yes	Hemophilia	☐ No	☐ Yes	Herpes	☐ No	☐ Yes
Persistent Cough	☐ No	☐ Yes	Sickle Cell	☐ No	☐ Yes	STI	☐ No	☐ Yes
Shortness of Breath	☐ No	☐ Yes	Von Willebrand	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes
Sleep Apnea	☐ No	☐ Yes	Other	☐ No	☐ Yes	Other	☐ No	☐ Yes
If yes, please explain:			If yes, please explain:			If yes, please explain:		

Ear / Stomach Problems			Heart Conditions					
Ear Tubes	☐ No	☐ Yes	Artificial Valve	☐ No	☐ Yes	High Blood Pressure	☐ No	☐ Yes
Ear Infections	☐ No	☐ Yes	Angina (Chest Pains)	☐ No	☐ Yes	Infective Endocarditis	☐ No	☐ Yes
Hearing Loss	☐ No	☐ Yes	Congenital Heart Defect	☐ No	☐ Yes	Low Blood Pressure	☐ No	☐ Yes
Reflux	☐ No	☐ Yes	Heart Attack	☐ No	☐ Yes	Mitral Valve Prolapse	☐ No	☐ Yes
Ulcers	☐ No	☐ Yes	Heart Disease	☐ No	☐ Yes	Pacemaker	☐ No	☐ Yes
If yes, please explain:			Heart Murmur	☐ No	☐ Yes	Rheumatic Fever	☐ No	☐ Yes
			If yes, please explain:					

Allergies			Other Conditions					
Dye	☐ No	☐ Yes	Arthritis/Rheumatism	☐ No	☐ Yes	Joint Replacement	☐ No	☐ Yes
Environmental	☐ No	☐ Yes	Cleft Palate	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes
Gluten	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	Liver Disease	☐ No	☐ Yes
Latex	☐ No	☐ Yes	Dialysis	☐ No	☐ Yes	Seizures	☐ No	☐ Yes
Milk	☐ No	☐ Yes	Dizziness/Fainting	☐ No	☐ Yes	Skin Rash	☐ No	☐ Yes
Seasonal	☐ No	☐ Yes	Drug Use	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Other	☐ No	☐ Yes	Eating Disorder	☐ No	☐ Yes	Thyroid Disorder	☐ No	☐ Yes
If yes, please explain:			Epilepsy	☐ No	☐ Yes	Tobacco Use	☐ No	☐ Yes
			If yes, please explain:					

Special Needs								
ADHD	☐ No	☐ Yes	Depression	☐ No	☐ Yes	Multiple Sclerosis	☐ No	☐ Yes
Autism	☐ No	☐ Yes	Developmental Challenges	☐ No	☐ Yes	Nervous Disorder	☐ No	☐ Yes
Behavior Disorder	☐ No	☐ Yes	Down Syndrome	☐ No	☐ Yes	Psychological Conditions	☐ No	☐ Yes
Bipolar Depression	☐ No	☐ Yes	Head Injury	☐ No	☐ Yes	Wheelchair	☐ No	☐ Yes
Cerebral Palsy	☐ No	☐ Yes	If yes, please explain:					
Anything not listed, please explain:								

AUTHORIZATION FOR CARE & TREATMENT: I hereby agree that Lakeshore Pediatric Dentistry, PLLC may perform care and examinations, laboratory tests and procedures (Including x-rays), administer local anesthetics, analgesia, medication and treatment, as may be directed by the treating practitioner. I acknowledge that no guarantees have been made to me as to the effects of such examinations, tests, procedures or treatment of the condition.

I will not hold my dentist, or any member of his/her staff responsible for any errors or omissions that I have made in the completions of this form. To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in patient information, medical status, insurance coverage, and familial status.

_____ _____

Patient Name (Print) **Patient/Parent/Agent/Guardian (Signature)**

_____ _____

Parent/Agent/Guardian (Print) **Relationship to Patient**