Dear patient,

Our office respects your privacy. We understand that your personal health information is sensitive. This Notice of Privacy Practices will tell you how we may use and share your health information.

**Uses and Disclosure of Your Personal Health Information**

**Your Authorization**. Except as outlined below, we will not disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. This form will describe what information will be disclosed, to whom, for what purpose, and when. You have the right to revoke that authorization in writing, except to the extent that we have already relied upon it.

**Uses and Disclosures for Treatment**. We will make uses and disclosures of your personal health information as necessary for your treatment. For instance, the professionals involved in your care will use information in your medical record to plan a course of treatment for you that may include procedures, medications, tests, etc. We may also disclose your personal health information to institutions or individuals that are or will be providing treatment to you.

**Uses and Disclosures for Payment**. We will make uses and disclosures of your personal health information as necessary for payment purposes. For instance, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you or we may use your information t0o prepare a bill to send to you or the person responsible for your payment.

**Persons Involved in Your Care**. Unless you object, we may in our professional judgment disclose to a member of your family, a close friend, or any other person you identify, your personal health information to facilitate that person’s involvement in caring for you or in payment for that care. We will tell them only what they need to know to help you. You have the right to say “no” to this use or to sharing your information. If you say “no,” we will not use or share your health information with your family or friends.

**Your Health Information Rights**. You have many rights under state and federal laws involving health information. We may not approve everything that you ask for, but we have ways of working with you if you disagree with us. You have a right to ask for and receive a paper copy of the most current notice of privacy practices and ask questions about it. You may also ask for the following, but you must ask in writing and there may be certain reasons under the law we cannot approve your request:

* To limit how we use your health information
* To have your health information sent to you in a private manner or a certain place
* To inspect and get a copy of your health information. There may be a fee for copies.
* To correct or add to your health information if you think it is wrong or something is missing.
* To withdraw your written approval of using and sharing your health information. We cannot take back information that has already been sent out.
* To obtain a list of who has received copies of your health information. You may get this list, without charge, once every 12 months.

**What We Must Do**:

* Keep your health information private and safe.
* Train our staff to keep your health information private and safe.
* Follow the information in this notice.
* Give you a copy of this notice, if requested.
* Tell you how to make a complaint.

We reserve the right to change this notice. We can give you the new notice by mail, fax, on your computer, or by handing you one in person.

**Minors**: Minors are children under the age of 18. Parents and legal representatives may see their minor child’s health information in most cases. In some cases, we are required by law not to give you access to your minor child’s health information such as treatment of substance abuse, mental health and STDs.

Under Federal Law, we may also use and share your information without your approval for the following reasons:

* To Report Suspected Abuse or Neglect: Of a child or adult to proper agencies.
* For Courts or Lawsuits: As required by a subpoena, court order or to defend a lawsuit.
* To Business Associates: These are people or agencies who help us serve you. The law says we can give them enough information to do their jobs. We require them to protect your information just like we do. For example, this could include a collection agency.

**To ask for help or Turn in a complaint**: Please contact our privacy officer if you have questions, need more information, or want to report a problem with your health information. If you believe your privacy has not been protected, you may talk to any staff member right away. You may also send a written complaint to our privacy officer. You may also file a complaint with the U.S. Secretary of Health and Human Services. We respect your right to file a complaint. If you complain you will not be punished. Our privacy officer is Roya Hyduk, M.P.H. and can be reached at (610) 691-0160 or by mail at 818 W Broad St Bethlehem PA 18018.

**Medical Consent**: I authorize Michael E. Hyduk DMD to perform an evaluation and any resulting treatments for my current condition at my request.

**Consent for the Release of Information**: I authorize the release of any information required by my insurance carrier, government agency, or any entity responsible for processing and paying my claims for dental benefits and such consent is valid for the life of the claim. I authorize information from my medical health record to be viewed by employees of my insurance company, their agents, or my healthcare providers. I understand that information from my medical record may be reviewed or released while I am receiving care or after discharge, and that this information will be held confidential, except as allowed by law.

**Statement of Financial Responsibility**: I understand that the office of Michael E. Hyduk DMD performs insurance billings and verifications as a courtesy, but that the ultimate financial responsibility is mine, and I agree to pay for services rendered according to the rates and terms of Michael E Hyduk DMD. I understand I am responsible for charges not covered by my insurance or other agency, which may include a deductible, copay or coinsurance due within 30 days of receipt. I understand that outstanding balances may be turned over to a collection agency after 90 days. As a parent or legal guardian of a minor patient, I agree to pay in accordance with the terms and conditions set forth in this financial policy. As a self-paying patient, I understand that I am responsible for payment by personal check, credit card or cash at the time of service.

**Assignment of Insurance Benefits**: I authorize all payment of insurance or health plan benefits directly to Michael E Hyduk DMD. If I am applying for payment under Medicaid, I request that payment of authorized benefits be made on my behalf. I am the patient, or I am authorized as the patient’s agent to execute the terms of this document, or I assume all financial responsibility by signing below:

**I certify that I have read, fully understand, and consent to the terms set forth in this document. I also certify that I received the notice of patient privacy practices and I understand my rights to privacy of my personal health information as defined within this document.**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Please Print)

**Patient Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_