SOUTHEASTERN PA ORAL SURGERY, LLC

USE AND DISCLOSURE OF 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.

We are required by law to maintain the privacy of your health facts and to provide you with the notice of our legal duties and privacy practices. We must follow the terms of the notice effective April 14, 2003. We do reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request.

As a client of ours, facts about you may be used and disclosed to other parties for treatment, payment and health care operations. These uses and disclosures require your consent, and include, but are not limited to the following information:

- A release of information contained in financial and or medical records
- Diseases spread person to person
- Drug and or alcohol abuse
- Medical History
- Treatment in progress
- Any other related facts

We may release the above to:

1. Your insurance company, Medicare, Medicaid, or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment
2. Any person from a program or an insurance company, who performs billing, quality and risk management tasks, such as insurance auditors and state Risk Management
3. Any personal care facility where you live
4. Any other doctor providing your care
5. Family members and other people who are part of your plan for service
6. State and Federal agencies acting on behalf of programs such as Medicare or Medicaid
7. Other health care people to start treatment

We may contact you via telephone, postcard or other mailings to:

1. Provide appointment reminders
2. Discuss issues involving payments on your account

We may use a sign-in sheet for:

1. The purpose of keeping track of patients that are being seen on a daily basis. This sheet is destroyed at the completion of each day.

We may take photographs to:

1. Use for decisions made in dental treatment
2. Posting within our offices for the purpose of showing the progression of treatment

We are allowed to use or disclose facts about you without consent in the following situations:

1. In emergency treatment situations, if we try to obtain consent as soon as possible after treatment
2. Where significant barriers to communication with you exist and we determine that the consent is clearly inferred from the situation
3. Where we are required by law to obtain treatment and we are unable to obtain consent
4. For certain public health activities, such as reporting injuries, death, diseases, etc.
5. Where the use or disclosure is required by law
6. Where we reasonably believe you are a victim of abuse, neglect or domestic violence
7. To coroners, medical examiners and funeral directors
8. For certain research purposes
9. For Workman's Compensation purposes
10. For specialized government functions, including custodial situations

We are allowed to use or disclose facts about you without consent or authorization provided you are informed in advance and given the chance to agree to, restrict or forbid the disclosure in the following situations:

1. The use of a directory of people served by us (clinic schedules, patient schedules)
2. To a family member, friend or other person you choose, who may assist in your care or payment for care

YOUR RIGHTS

You have the right, subject to certain conditions, to:

1. Request restrictions on certain uses and disclosures of facts about you; however, we are not required to agree to the requested restrictions
2. Receive confidential communication by giving us another address
3. Inspect and receive a copy of protected health data by filling out our request form

4. Receive a list of disclosures made of your protected health data by filling out our request form
5. Amend protected health data by filling out our request form
6. Obtain a copy of this notice at any time

COMPLAINTS

You may complain to us and the Secretary of the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. The complaint must be filed in writing with us and must state the specific incident(s) including the date, what happened and details of the incident.

For details about filing a complaint with us, contact:

Carol Martin, HIPAA Compliance Officer
Southeastern PA Oral Surgery, LLC

Temple University Hospital
Eiscopal Division
100 E. Lehigh Avenue
Philadelphia, PA 19125
(215) 707-3613

ACKNOWLEDGEMENT

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I hereby certify that I have received a copy of Southeastern PA Oral Surgery, LLC notice of Privacy Practices.

_____ ____/____/____
Printed Name of Recipient Date

_____
Signature of Recipient

FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices from the above referenced individual, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency prevented us from obtaining acknowledgement

_____ Other (Please specify)

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