



# BEFORE 3 PEDIATRIC DENTISTRY

preventive & comprehensive dental care. BEFORE age 3 through adolescence

DR. KIMBERLY M. GILL

## NOTICE OF PRIVACY PRACTICES

### THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

#### Our Legal Duty

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect \_\_\_\_\_ 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. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, 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 additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Your Authorization: In addition to our use of your health information for treatment, payment or 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 an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

#### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you without authorization for the following purposes:

**Treatment:** We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other health care provider providing treatment which we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

**Payment:** We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

**Health care Operations:** We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualification of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

**Unsecured Email:** We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

**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 both. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use 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 supplies, x-rays, or other similar forms of health information.

**Disaster Relief:** We may use or disclose your health information to assist in disaster relief efforts.

**Marketing Health-Related Services:** We may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

**Change of Ownership:** If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Public Health:** We may, and are sometimes legally obligated, to disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.



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**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 or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, 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 contact you to provide you with appointment reminders via voice mail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

**Sign In Sheet and Announcement:** Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

**Decedents:** We may disclose health information about a decedent as authorized or required by law.

### 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 practicably 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 contacting our office. 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. If you request copies, there may be a charge for time spent. If you request an alternate 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. Contact us for a full explanation of our fee structure.

**Disclosure Accounting:** You have a right to receive a list of instances in which we 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 your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out-of-pocket in full.

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

**Breach Notification:** In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

**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:** You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our website or by electronic mail (Email).

**Research:** Your health information may be disclosed to researchers for research purposes. In this situation written authorization is not required as approved by an Institutional Review Board or privacy board.

**Fund raising:** We may use or disclose demographic information and dates of treatment in order to contact you for fund raising activities. If you no longer wish to receive these communications, notify us at the contact information provided below and we will stop sending further fund raising information.

### Questions and Complaints:

If you want more information about our privacy practices, or have questions or concerns, please contact Jeanette at (614) 870-1333. You may also fax your questions or concerns to (614) 870-1333, email to [contactus@B3PD.com](mailto:contactus@B3PD.com) or mail to 982 Galloway Rd., Galloway, OH 43119.

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 in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We will not retaliate against you for filing a complaint.

982 Galloway Rd, Galloway, OH 43119 • [www.B3PD.com](http://www.B3PD.com) • ph 614.870.1333 • fax 614.870.0333



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## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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**\*\*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT\*\***

I, \_\_\_\_\_ have received a copy of Kimberly M. Gill, DDS, MS, LTD Notice of Privacy Practices.

Patient's Name \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

If this acknowledgement is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

### FOR OFFICE USE ONLY...

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

- Individual refused to sign \_\_\_\_\_
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify) \_\_\_\_\_



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## OFFICE POLICY AND CONSENT FORM

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We are here to serve you in a comfortable and professional atmosphere. Our goal is to provide your child with the very best quality of dental care.

### INSURANCE & PAYMENT INFORMATION:

**• FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.**

For patients with dental insurance: We will file your claim for you at no charge, however, we ask that your deductibles and your estimated portions (20-60%) be paid as time services are rendered. Please note, your dental insurance is designed to be of assistance to you and may not always cover all dental expenses.

• All insurance benefits are assigned to Dr. Gill unless services are paid in full at time of treatment.

• For your convenience, we accept Visa, MasterCard, Discover, Care Credit\* and cash.

For treatment involving fees above \$500.00, special financial arrangements may be discussed with our office manager.

[\*Care Credit offers monthly payment plans. For more information, please ask our staff or visit [www.carecredit.com](http://www.carecredit.com)]

### APPOINTMENT POLICIES:

Your appointment time is set aside especially for your child. We ask for courtesy to the doctor(s) and to other patients that you keep these scheduled appointments. If you must change or miss an appointment, please notify this office as soon as possible – preferably a two-business day notice. Cancellations or broken appointments could result in a charge of \$35 or no re-appointment.

### REFERRALS:

A referral is not required in order to schedule an appointment. However, if your child has been referred to us, this appointment is a consultation visit and the first time your child is being seen by a pediatric dental specialist. At this first visit, the doctor will complete an exam/ assessment and then present to you any plans/ options for treatment.

Please note that treatment will not be performed at the consultation visit unless deemed necessary by the examining dentist.

### IN-OFFICE TREATMENT VISITS:

Dr. Gill and her staff are very excited for the opportunity to provide quality oral health care and education to you and your child! We would like for you to know we are going to try our very best to make your child's visit for dental treatment a positive one. If, however, your child will not cooperate for their visit, a 10 minute time frame begins where you will have the opportunity to give your child a pep-talk in hopes of alleviating any fears they are experiencing. If, after that time, your child still will not cooperate, his/ her appointment will end. Options to complete all needed dental treatment under sedation (i.e. general anesthesia in an outpatient hospital setting) will be presented to you and you will be able to decide whether or not to have any remaining treatment on your child scheduled accordingly. We understand that failed treatment appointments are very frustrating, not only for parents but for our office as well. Your child's safety is our biggest concern and sedation dentistry is often a viable option and frequently the best option, especially in younger children that may need extensive dental treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### CONSENT FOR TREATMENT ON YOUR CHILD (OUR PATIENT):

I have read and understand the above information. The undersigned hereby authorizes the doctor(s) to perform those diagnostic and treatment procedures, including local anesthesia as deemed necessary. These treatments will be discussed with legal parent or guardian prior to any treatment being performed. If your child(ren) ever have any change in health or change in medication, I will inform the doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the doctor and authorizes the release of dental records to my insurance company.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_