NOTICE OF PRIVACY PRACTICES

Effective Date: 2019

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Title: Privacy Officer Julie Anderson
Telephone: (920) 592 – 8940
Fax: (920) 592 – 8953
Email: info@kidsdentalexperts.com
Address: 125 Siegler St., Green Bay WI 54303

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page, and will remain in effect unless 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 any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you the revised notice. Any revised notice will be effective for all health information that we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website if applicable. You may request a copy of the current notice at any time.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist, a physician or other health care provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management, and general administration, including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has or had a relationship with you and the medical information is for that provider's or plan's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of any of these communications.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services, and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.

Additional Restrictions on Use and Disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You should submit your request in writing to our Privacy Officer.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Officer for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your medical information. You should submit your request in writing to our Privacy Officer.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we deny your request, you may have a statement of your disagreement added to your medical information. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. Except in limited circumstances, we are not required to agree to your request. But if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and

2. the medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Privacy Officer to obtain this notice in written form.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact to our Privacy Officer.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Staff initials _____

Kids Dental Experts ®
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PRIMARY DENTAL INSURANCE

Insurance Company

Ins. Company Address

City, State, & Zip Code

Insurance Phone Number

Group Number

Member ID

Subscriber's Name

Subscriber's Employer

Subscriber's Home Address

City State Zip

Subscriber's Social Security Number Date of Birth

Relationship to Patient

SECONDARY DENTAL INSURANCE

Insurance Company

Ins. Company Address

City, State, & Zip Code

Insurance Phone Number

Group Number

Member ID

Subscriber's Name

Subscriber's Employer

Subscriber's Home Address

City State Zip

Subscriber's Social Security Number Date of Birth

Relationship to Patient

Are natural parents (circle): Married Divorced Separated Widowed Never Married

With whom does the child(ren) reside? _____

List all children covered under policy:	Sex	Date of Birth
1. _____	M F	_____
2. _____	M F	_____
3. _____	M F	_____
4. _____	M F	_____
5. _____	M F	_____

Insured parties are responsible for knowing their benefits. Any charges not covered are due at the time of the appointment.

_____ _____ _____

Signature Relationship to patient(s) Date

PATIENT REGISTRATION

Patient Name_____Date of Birth_____Sex_____Phone # (_____)_____
Home Address _____ Mailing Address _____
Name, Address, Telephone and E-mail Address of Legal Guardian _____
_____
Whom may we thank for referring you to our office? _____
List the names of other immediate family members who are patients at Kids Dental Experts_____
_____
School Attending _____ Favorite interest/hobby _____
Nickname_____

PARENT / GUARDIAN INFORMATION

Father's Name _____ Mother's Name _____
E-mail Address_____ E-mail Address_____
Address (if different from patient) _____ Address (if different from patient) _____
_____ _____
Phone #_____Cell # _____ Phone #_____Cell # _____
Birthdate_____Social Security #_____ Birthdate_____Social Security #_____
Employer and Position_____ Employer and Position_____

Parents' Marital Status: ___Married ___Divorced ___Single ___Widowed ___Separated

Stepmother's Name_____ Stepfather's Name_____
E-mail Address_____ E-mail Address_____
Address (if different from patient) _____ Address (if different from patient) _____
Phone #_____Cell # _____ Phone #_____Cell # _____
Birthdate_____Social Security #_____ Birthdate_____Social Security #_____
Employer and Position_____ Employer and Position_____

MEDICAL HISTORY

Child's Physician_____ Hospital/Clinic_____ Phone # (_____)_____
Date of last physical examination_____Results _____

	Yes	No
Is child under the care of a physician? Explain_____	☐	☐
Is child receiving any medications or drugs? List and Explain reason for taking:_____	☐	☐
Has your child ever been hospitalized? Explain_____	☐	☐
Any excessive or prolonged bleeding when cut? Explain_____	☐	☐

	Yes	No
Has your child ever had surgery? Explain_____	☐	☐
Is your child allergic to any of the following? ☐ Penicillin ☐ Latex products ☐ Local anesthetic Other drugs (list)_____	☐	☐
Does your child have good physical coordination?	☐	☐
Are there any emotional problems? Explain_____	☐	☐

	Yes	No
Does your child frequently encounter stressful situations at home or school? Explain_____	☐	☐

Please describe any current medical information we need to be aware of that has not been covered. (such as pending surgeries or recent injuries)
_____
_____

Please check if child has any history of difficulty with any of the following:

___ADD (Attention Deficit Disorder)
___ADHD (Attention Deficit Hyperactive Disorder)
___AIDS (HIV)
___Anemia
___Arthritis
___Anorexia
___Asthma _____frequency of attacks
____exercise induced
___Autism
___Bladder
___Blood pressure concerns
___Blood transfusion
Explain_____
___Bruises easily
___Chicken Pox
___Convulsions/Epilepsy/Seizures
___Depression
___Diabetes
___Fainting spells
___Hearing impaired
___Heart condition
Explain_____
(your child may require antibiotic before dental treatment)
___Hepatitis Type A B C Other____
___Hives or skin rash
___Liver disease
___Malignancies
___Mastoid
___Measles
___Mononucleosis
___Mumps
___Nervousness
___Persistent cough or coughs up blood
___Rheumatic fever
___Thyroid
___Tuberculosis
___Venereal disease
___Surgery or radiation treatment for tumor, growth or condition of the head or neck

See Reverse

DENTAL HISTORY

Most important dental concern _____

Date of last dental visit _____ Type of Service _____

	YES	NO
Has your child complained about dental problems? (Explain)	☐	☐
Any problem associated with previous dental treatment? (Explain)	☐	☐
Any unhappy dental experiences? (Explain)	☐	☐
Has your child had any injuries to the mouth, teeth or head? (Explain)	☐	☐

How would you describe your child's attitude toward dentistry? _____

Please check the following to indicate "Yes" regarding this patient.

___apthous ulcers frequent (canker sores)
___breath odor
___herpetic lesions frequent (cold sores)
___earaches
___headaches
___jaws make a clicking, grinding or popping noise
___neck pain
___orthodontic concerns (crooked teeth or bite)
___snore at night
___speech impaired/unusual speech habits
___teeth grinding
___teeth clenching
___mouthbreathing
___nail biting
___lip biting or sucking
___nursing or bottle habit
___pacifier____frequent___occasionally
___self induced purging (bulimia)
___thumbsucking___frequent___occasionally
___finger sucking___frequent___occasionally
___smoking
___chewing tobacco
___frequent consumption of carbonated beverages
___strong gag reflex
___frequent vomiting

Fluoride/Decay Risk Assessment

	Yes	No	Unsure
Is fluoride taken in any form?	☐	☐	☐
Is fluoride in your water supply?	☐	☐	☐
(Green Bay city water is fluoridated)			
Number of days in daycare_____			
Fluoride toothpaste/rinse used	☐	☐	☐
History of decay in family?	☐	☐	☐

	Yes	No	Unsure
Mother's side?	☐	☐	☐
Father's side?	☐	☐	☐
Brothers or Sisters with decay?	☐	☐	☐

	Yes	No	Unsure
Does your child brush teeth daily?	☐	☐	☐
How many times each day?_____			
Do your child's teeth get flossed daily?	☐	☐	☐
How many times each day?_____			

How do you feel about preserving baby teeth? ____Important ____Not important ____No opinion

*** * * PLEASE COMPLETE THIS SECTION IF CHILD IS 18 MONTHS OR YOUNGER * * ***

Birth History

Birth Length _____inches
___Full Term
___Premature _____ Weeks
___Normal Delivery
___Caesarean Section
___Forceps Delivery
___Complications during delivery
Explain:_____

Did your infant experience any of the following during the first few weeks of life?
____jaundice ____breathing difficulties
____feeding difficulties ____high fevers
____serious illness ____intubation
____other_____

Did you experience any of the following during pregnancy?
____severe morning sickness
____physical trauma or injury
____medications taken Explain_____
Illness *(not including colds or flu)*_____

Feeding History *(Please check all that apply.)*

____Breast feeding
How long? ____years ____months
Schedule frequency:
____on-demand feeding
____bedtime
____supplemental bottle
Began when? ____months
____weaned____months
____currently breast feeding

____Bottle feeding
____ready to feed formula
____formula reconstituted with water
Average time of each feeding_____
____bedtime bottle
Contents of bottle_____
____bottle is used as a pacifier
Contents of bottle_____
____weaned from bottle____months

Notes:

I have completed the requested information on this form to the best of my knowledge.

Date_____ Signature_____Relationship to child _____

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FINANCIAL POLICY & ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Please list all children that are seen at Kids Dental Experts®:

Patient Name _____ Date of birth: _____
Patient Name _____ Date of birth: _____
Patient Name _____ Date of birth: _____
Patient Name _____ Date of birth: _____
Patient Name _____ Date of birth: _____
Patient Name _____ Date of birth: _____

PAYMENTS: Fees not covered by insurance and deductibles will be collected at the time of service. Payments are accepted in the form of cash, check, debit, money order, MasterCard, VISA, Discover, American Express, HSA accounts, and CareCredit. A courtesy discount of 5% will be granted to those who have no outstanding balance and are paying in full with cash or check for that day's services. A monthly 1% (12% yearly) or a minimum of $2.00 past due fee will be charged on any delinquent account. A $25.00 service fee will be charged to your account if a check is written with insufficient funds.

RESPONSIBLE PARTY: Parents are responsible for the entire account balance and will be billed accordingly. Any arrangements made through a divorce are strictly between the parents and do not involve our office. When children turn 18 years of age, parents will be given the option to continue to be responsible for that child's expenses or have the child assume responsibility of their own account.

FAILED/MISSED APPOINTMENTS: Please call with cancellations or to reschedule appointments as soon as possible. A reservation fee may be charged for missed appointments or cancellations with less than 48 hours' notice.

INSURANCE: I authorize payment from my dental benefits carrier directly to Kids Dental Experts®. I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and by signing this statement, I agree that I am financially responsible for payment of the remaining amount. Insurance delays or lack of coverage does not exempt me from making payment within 45 days of services rendered. Any balance not paid within 45 days will be subject to collection proceedings. As a courtesy, the office offers the option of storing my credit, debit, or HSA card information on file so that any remaining balances after insurance settlements can be processed automatically.

PRIVACY PRACTICES:
I consent to the diagnostic procedures & treatment deemed necessary by the dentist for proper dental care. To carry out treatment, obtain payment, and for health care operations that are related to treatment and payment, the disclosure of my child's records may occur. I have received the form titled NOTICE OF PRIVACY PRATICES to keep for my records.

Signature: _____ Date: _____
Printed Name: _____ Relationship to patients above: _____

OFFICE WITNESS
Printed Name: _____ Date: _____ Title: _____

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PATIENT INFORMATION AUTHORIZATION

This form is to be completed for any person in addition to the natural mother, father, or legal guardian that may bring your child/children in for their dental appointments. This authorization will remain in effect until it is revoked in writing by the natural mother, father, or legal guardian.

Patient Name _____ Birthdate _____

Patient Name _____ Birthdate _____

Patient Name _____ Birthdate _____

Patient Name _____ Birthdate _____

Patient Name _____ Birthdate _____

I hereby authorize Kids Dental Experts® to release and discuss all information regarding dental visits to the individuals listed below, and these individuals may consent to dental treatment for all patients listed above.

1. _____ _____
(Print Name) (Relationship to patient)

2. _____ _____
(Print Name) (Relationship to patient)

3. _____ _____
(Print Name) (Relationship to patient)

4. _____ _____
(Print Name) (Relationship to patient)

5. _____ _____
(Print Name) (Relationship to patient)

Signature: _____ Date: _____
(Natural mother, father, or legal guardian)