Dr. Roland Nentwich DDS, MS, PC. Orthodontist & Dentofacial Orthopedist
506 Main St. Shrewsbury, MA 01545 (508)845-6711
1084 Main St. Holden, MA 01520 (508)829.4309

Dr. Roland Nentwich D.D.S., M.S., P.C.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATIONABOUT YOU MAY BE USED AND DISCLOSEDAND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

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 the change 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 upon request. You may request a copy of our Notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about your treatment, payment, and healthcare options. For Example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use and disclose your health care information to obtain services we provide to you.

HEALTHCARE OPERATIONS: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare 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 was 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.

TO YOUR FAMILY & FRIENDS: We must disclose your health information to you, as described in the Patient Rights sections of this Notice. We may disclose your health information to a family member, friend, or the person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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 for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object 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 healthcare. 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.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that your 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 or safety or the health of others.

NATIONAL SECURTITY: 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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, messages, postcards, e-mails, text messages or letters).

PATIENTS RIGHTS
ACCESS: You have the right to look at or obtain 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 request unless we cannot practicably do so. You may make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you $1.00 per page and $25.00 per hour for staff time to locate and copy your health information, and postage if you want copies to be mailed to you. If you request an alternative 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.

DISCLOSURE ACCOUNTING: You have the right to receive a list of insurances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. 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.

RESTRICTIONS: 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 an emergency).

ALTERNATIVE COMMUNICATIONS: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must have this request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location request.

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.

QUESTIONS AND COMPLAINTS
If you are concerned that we may have violated your privacy rights, or you disagree with the decision we made about access on 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, please submit a complaint in writing. You may also submit a complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health 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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I _____ have received a copy of Dr. Roland Nentwich's office Notice of Privacy Practices.

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Signature_____ Date_____

Patient Under 18 Years of age
I (Parent/ Legal Guardian) of _____ have received a copy of Dr. Roland Nentwich's office Notice of Privacy Practices.

Signature_____ Date_____

Patient Contact Consent Form

I consent and agree that the office of Dr. Roland Nentwich may contact me and leave a message in regard to orthodontic treatment, payments and appointment confirmations at the following:

(Appointment reminders will be sent via phone/text/e-mail)

Home Phone Number - _____

Cell Phone Number - _____

E- Mail -_____

Work Number - _____ Emergency Contact _____

Signature_____ Date_____

I consent and agree that the office of Dr. Roland Nentwich may contact and leave a message with the following person or persons in regard to orthodontic treatment and appointment confirmations.

Name_____ Relationship to patient_____

Contact Number _____

- I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature_____ Date_____

For Office Use Only

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

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