PACE DENTAL
on Pleasant Street
State of the Heart Dentistry
703.938.6800
www.dentistvienna.com

NOTICE OF PRIVACY PRACTICES FOR 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.

Our Privacy Pledge

We want you to understand that we respect your privacy. Other than the necessary uses and disclosures we described below, we will not sell your health information or provide any of your health information to any outside marketing company.

Uses and Disclosures

Below you will find examples of how we may have to use or disclose your health care information:

1. Your doctor or a staff member may have to disclose your health information (up to and including all of your clinical records) to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.

2. It may be necessary for our insurance and/or billing staff to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, your employer, a family member, other relative or close personal friend, who is involved in our care or to facilitate the payment related to your care.

3. It may be necessary for the doctor and members of the staff to use your health information, examination, and treatment records, and billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.

4. Your doctor and members of the practice staff may need to use your information (ex. name, address, phone number, and your clinical records) to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine. You may inspect or copy the information that we use to contact you.

As our patient, you possess the right to refuse to give us the authority to disclose this information. If you refuse authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I understand Pace Dental has the right to change its Notice of Privacy Practices from time to time and that I may contact Pace Dental at any time to obtain a current copy of the Notice of Private Practices.

Patient Name: _____

Relationship to Patient: _____

Authorized Signature: _____Date:_____

I authorize the following person(s) to receive information on my behalf when/if necessary.

Name_____Relationship to Patient_____

Address_____City_____State_____Zip_____Phone_____

Patient signature_____Date_____

Name_____Relationship to Patient_____

Address_____City_____State_____Zip_____Phone_____

Patient signature_____Date_____