HANSWIRTH DENTISTRY, LLP
30 LAKE STREET #IF
White Plains, New York 10603
1(914) 946 -1500

INSTRUCTIONS FOR OUR NOTICE OF PRIVACY PRACTICES

PURPOSE: This Notice of Privacy Practices presents the information that the HIPPA Privacy Rules require us to give our patients regarding our privacy practices and their privacy wrights.

We must provide this Notice to each patient no later than the due date of our first service delivery to the patient, after April 14th, 2003. We must also have these Notices available at the office if the patient requests to take a copy with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patient seeking service from us to be able to read the Notice. Whenever we revise the Notice we must make the Notice available for patients upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised notice in our office as discussed above.

We must make a good faith effort to obtain a written acknowledgement of receipt on this Notice from each individual with whom we have direct treatment relationship and to whom we provide this Notice, except in emergency situations. If we do not obtain the acknowledgement, we must document our efforts and the reason we did not obtain the acknowledgment. The last pane of the Notice is a written acknowledgement that each patient should sign, We should keep acknowledgment in the patient's medical record.

HANSWIRTH DENTISTRY, LLP
30 LAKE STREET #IF
White Plains, New York 10603
1(914) 946 -1500

- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for the purpose of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organization;
- to avert a serious threat to health safety,

in connection to certain research facilities;

- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

PATIENT RIGHTS

ACCESS: You have the right to took 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 practically do so. You must make a request in writing to obtain access to your health information. You may access by sending us a letter to the address at the end of this notice. If you request copies, we will charge a reasonable cost-based fee for proving your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14th, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than ounce in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information.

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 theses additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about about your health information by alternate means or to alternative locations. You must make a request in writing. You must specify in your request the alternative means or location, and provide a satisfactory explanation how you will handle payment under alternative means or location that you 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 we should amend such information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice. If you believe that:

- we have violated your privacy rights;
- we made a decision about access to your health information incorrectly;
- our response to a request you made to amend or restrict the use and disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations.

You may contact us using the information listed below. You may also submit a written 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.

DENTIST CONTACT OFFICE: Hanswirth Dentistry LLP

HANSWIRTH DENTISTRY, LLP
30 LAKE STREET #IF
White Plains, New York 10603
1(914) 946 -1500

NOTICE OF PRIVACY PRACTICE
THIS NOTICE DESCRIBES HOW HEALTH 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 HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTIES
Federal and state law requires us to maintain the privacy of your health information. The law also requires us to give you notice about our privacy practices, our legal duties, and rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effort. This notice takes effect April 14,2003, 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 applicable law permit the change. We reserve the right to make changes in out privacy policies practices and the new term of our notice effective for the health information that we maintain, including health information we created or received before we made the changes before we make a significant change in out practices, we will change this notice and make the new notice upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about your treatments payment and health care operations. For example:
TREATMENT: We may use your pertinent health information for treatment or disclose it to the dentist, physician or other health care provider providing treatment to you.
PAYMENT.- We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Ruled for its payment activities.
HEALTH CARE OPERATIONS: We may use and disclose your information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal; privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your health information to help these organizations to conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.
ON YOUR AUTHORIZATION: You may give us 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 uses or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described by this notice.
TO YOUR FAMILY AND FRIENDS-. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people we will provide you with the opportunity to object to our use or disclosure. If you arc not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences in your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your cam, of your location and general condition.
APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders such as voicemail messages and general condition.
DISASTER RELIEF: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.
PUBLIC BENEFIT: We may use or disclose your health information as authorized by law for the following purpose deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistics reporting, child abuse reporting, FDA oversight and to employers regarding work-related injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;

HANSWIRTH DENTISTRY, LLP
30 LAKE STREET #IF
White Plains, New York 10603
1(914) 946 -1500

SECTION A: The Patient

NAME: _____

ADDRESS: _____

TELEPHONE: _____

PATIENT #_____ SOCIAL SECURITY NUMBER: _____

SECTION B: Acknowledgment Of Receipt Of Privacy Practices Notice

I _____, acknowledge that I have received a notice of Privacy Practices from the above named practice.

IF A PERSONAL REPRESENTATIVE (GUARDIAN) SIGNS THIS AUTHORIZATION ON BEHALF OF AN INDIVIDUAL, COMPLETE, THE FOLLOWING.

Personal Representative's Name: _____

Patient's Name: _____

Representative's Relationship To Patient: _____

SECTION C:
Good Faith Effort To Obtain Acknowledgement Of Receipt
Describe your good faith effort to obtain the individual's signature on this form:

_____

_____

_____

Describe the reason why the individual would not sign the form:

_____

_____

_____

Signature: I attest that the above information is correct.

Signature:_____ Date: _____

Print Name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.
Acknowledgement of Receipt of Privacy Practices Notice