

Willham Orthodontics, PC
7400 Fleur Ste. 100
Des Moines, Iowa 50321
515-285-6134

Privacy Policy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully. The purpose of HIPAA is to insure the confidentiality of your health information. We want you to know about these policies and procedures which we developed, to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and our rights as our valuable patient.

We will use and communicate your health information only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health care information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

HOW YOUR HEATH INFORMATION WILL BE USED:

To Provide Treatment:

We will use your health information within our office to provide you with the best orthodontic care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between the orthodontist, orthodontic assistant, and business staff. In addition, we may share your health information with physicians, referring dentists, other specialists, clinical and dental laboratories, pharmacies or other health care personnel providing your treatment.

To Obtain Payment:

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically.

In Patient Reminders:

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you and your family. These notices may include postcards, letters, emails, texts or telephone reminders.

Abuse or Neglect:

We will notify government authorities if we believe a patient is a victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Family, Friends and Caregivers:

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask you, your permission first. In case of emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

PATIENT RIGHTS:**Restrictions:**

You have the right to request restrictions on certain utilizations and disclosures of your health information. Our office will make every effort to honor reasonable restriction from our patients.

Confidential Communications:

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable request for confidential communications.

Inspect and Copy Your Health Information:

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information:

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. In order to standardize our process, please provide us with your request in writing and describe the reason for the change.

Documentation of Health Information:

You have the right to ask us for a description of how and where your health information records are used by our office for any reason other than for treatment, payment, or health operations. Our documentation procedures will enable us to provide information on health information usage from April 2003 forward.

Request a Paper Notice of This Notice:

You have the right to obtain a copy of this Notice of Privacy of Practices directly from our office at any time. Stop by or give us a call and we will mail you a copy. We are required by law to maintain the privacy of your health information and to provide to you and your representative the Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices, we will be sure all our patients receive a copy of the revised notice.

Violation of Your Rights:

If you feel your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office Privacy Person. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

NAMES AND ACCESS INFORMATION:

In accordance with the Personal Information Privacy Act: I consent to the following parties having access to medical/ dental/ financial information regarding my orthodontic treatment:

RE: _____

Mother: _____ Father: _____

Step-parent(s)/ Guardian(s): _____

Spouse: _____

Dentist: _____ Physician: _____

Dental Insurance Company: _____

Other(s): _____

Signed: _____