

***Stanley F. Kayes, DDS***  
**NOTICE OF PRIVACY PRACTICES**

This notice describes how personal health information (PSI) about you may be used and disclosed and how you may obtain access to this information. Please review it carefully.

**OUR LEGAL DUTIES**

We are required by federal and state law to maintain the privacy of your health information. We are required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. This notice takes effect 4/14/ 2003 and will remain in effect until there is any revision of these practices.

We may change our privacy practices and the terms of the notice at any time, as permitted by law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information we maintain, including health information we created or received before we made the changes. Before we make a significant change in privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of this notice at any time. For more information about our privacy practices, or for a copy of this notice, you may contact this office at (703) 754-2300.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We may provide information to others regarding your medical/dental records in the area of treatment, payment, or health care operations in the following circumstances.

**Treatment:** We may need to obtain information or share information about you with **other dentists or physicians** to make sure that all providers are aware of conditions about which they need to be informed. This can include a need to call your physician or previous dentist for medical history information or to relay information concerning a medical or dental situation that arose during dental treatment. We also share information with **dental specialists** regarding your dental treatment, and will provide information as needed to pharmacists or other medical providers who may have a need to know about your medical/dental condition.

We do communicate with **dental laboratories** or other businesses such as **pharmaceutical companies** or **dental supply companies** as necessary to provide or obtain information regarding your personal dental treatment.

**Payment: Insurance companies** require as condition of payment to know what treatment was performed, and may require additional medical information to make decisions regarding coverage in specific circumstances. This can include releasing medical history information if necessary to document need for treatment.

With family insurance coverage, particularly if you are relying on another person to provide payment for your dental treatment, we may need to provide information to that family member to obtain payment or to relay benefit information. This information may be provided to a spouse, parent, or adult child of a dependent parent.

We may share financial information on delinquent accounts for the purposes of collecting fees due. This may involve attorneys and their collection staff members, collection agency officials, or court officials.

**Healthcare Operations:** We may use or disclose your health information to provide quality assessment, evaluate employee performance, conduct training programs for employees or students or interns, and for accreditation, certification, licensing or credentialing activities.

**Family Members or Designated Caregivers:** We need to be able to provide communication with you or to relay information to other family members or caregivers regarding medical, dental or account billing information. We will honor your privacy wishes if you express them below. Normally we contact you by home or other specified daytime phone number, or by mail to you personally or to person responsible for your account.

We reserve the right to use our professional judgement and experience in communicating with others who are responsible for your care, involving such areas as picking up x-rays, prescriptions, or disseminating educational materials. We may also contact family members, a listed emergency contact, or others who in our judgement may be able to provide assistance for you (such as a co-worker, neighbor, or friend) if necessary in an emergency situation.

**Required By Law:** We may, in rare circumstances, need to communicate your personal health information as required by law in the following instances. We may communicate with law enforcement officials or security officials in criminal matters or cases of national security, or judicial officials in criminal or civil court cases. We may relay information to workman's compensation officials for documentation of claims. We may communicate with public health or safety officials concerning an individual's health situation, to report abuse, or to report unusual findings important for public health or safety. We may communicate with military officials for armed services members, as requested for records needs. We may report incidents such as drug reactions to the United States Department of Health and Human Services. We may also release personal health information to government agencies or hospitals for patient identification purposes upon death or serious injury.

**Patient Reminders and Basic Communication:** Unless otherwise specified, this office may call a patient at home or work, and may leave a message with another person or with an answering machine for communicating basic information. This would include appointment time reminders, requests for basic insurance information, or a need to call the office for further discussion of other issues.

**PATIENT RIGHTS**

You have the right to access your health information. You have the right to request restrictions as to how your information is shared, to request that we amend your health information, or to request alternative means by which we communicate your health information to you. All requests must be made in writing. While we will accommodate reasonable restrictions as to sharing of information or alternative communication means, we are not required to agree to all requested restrictions or amendments. We may decline to provide treatment if you refuse to sign this acknowledgement, revoke this request at a later date, or request a specific restriction or amendment that we can not accommodate. You have the right to revoke this consent at a later date in writing, but that will not affect disclosures made before the revocation date. You have the right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, or healthcare operations for dates after April 14, 2003.

**QUESTIONS AND COMPLAINTS**

If you want more information you may contact us. You may also file a complaint with us or with the U. S. Department of Health and Human Services. We support your right to privacy of your personal health information and will not retaliate in any way if you choose to file a complaint. The privacy contact person for this practice is Maureen Kayes, who can be contacted at (703) 754-2300, or by mail at P.O. Box 40, Haymarket, VA 20168.

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I acknowledge receipt of a copy of this office's Notice of Privacy Practices. I understand that I have been given the opportunity to discuss privacy concerns and to express my wishes regarding dissemination of my confidential medical/dental or financial information.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
of Patient or Parent or Legal Guardian

Printed Name of Patient \_\_\_\_\_

**Please write yes or no to each possibility for communication.**

You may specify a limit to appointment reminder only for any of the following communication methods by adding the letters ARO after your yes or no answer; otherwise, communication may include medical, account, or insurance information.

Leave message with spouse \_\_\_\_\_

Leave message with other family member (including children or parent of patient) \_\_\_\_\_  
(you can specify a limit of communication to specific individuals as listed)

\_\_\_\_\_  
Leave message with specified relative or friend (give name and phone number if different from home telephone number) \_\_\_\_\_

Leave message on home answering machine \_\_\_\_\_

Contact at work \_\_\_\_\_ Leave message on voice mail at work \_\_\_\_\_

Leave message with office secretary or other office worker answering telephone \_\_\_\_\_

please specify any limits or list designated secretary with whom we may communicate \_\_\_\_\_

By e mail to designated address (please specify ) \_\_\_\_\_

By fax to designated home number (please specify number) \_\_\_\_\_

By fax to designated office number (please specify number) \_\_\_\_\_

(Fax information is generally for forwarding insurance information, medical instructions or to provide a family member with report of a dependent's dental information)