James G. Mace, D.D.S., P.C.

Notice of Privacy Practices

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.

This notice applies to the dental office and services listed under the Contact Information.

Our Legal Duty

By law, we must keep protected health information ("PHI") private. The federal government defines protected health information as any information, whether oral, electronic or paper, which is created or received by Dr. Mace or staff, and relates to a patient's health care or payment for the provision of medical services. This includes not only the results of tests and notes written by doctors, nurses and other clinical personnel, but also certain demographic information (such as your name, address and telephone number) that is related to your health records.

We are required by law to give you this notice and to follow the terms and conditions of the notice that is currently in effect.

The Health Care Providers Covered By This Notice

This notice covers Dr. James G. Mace, staff, volunteers, students, and trainees. The notice also covers other health care providers that come to this office to care for patients (such as physicians, physician assistants, therapists, and other health care providers not employed by Dr. Mace), unless these other health care providers give you their own notice of privacy practices that describes how they will protect your medical information. We may share your medical information with these other health care providers for treatment, payment and health care operations purposes. This arrangement is only for sharing information and not for any other purpose.

Use and Disclosure of (PHI):

Below is a list of the most common circumstances in which we may use or share your PHI:

For Treatment: We may need to use or share PHI about you with people involved in your care. For example, a doctor may need to look at your medical history before treating you.

For Payment: We may use and disclose your protected health information to bill and receive payment for the care and treatment that you received. For example, we may share your medical information with your insurance company about a service you received at this office so that your insurance company can pay us or reimburse you for the service.

For Health Care Operations: We can use and disclose protected health information about you for our operations. For example, we may share PHI about you to evaluate our doctors' and staffs' performance in caring for you.

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Other Uses and Disclosures of PHI:

We may also use or share PHI in the following circumstances:

When it is needed for public health activities; we are required or permitted by law to report the occurrence of communicable diseases.

When reporting information about victims of abuse, neglect or domestic violence;

When sharing information for the purpose of health oversight activities; we may share your PHI with the agency that oversees health care system programs, such as Medicare and Medicaid.

When sharing information for judicial and administrative proceedings; we may share your PHI in response to a legal order or other lawful process.

When sharing information for law enforcement purposes; we may share your PHI with the police or other law enforcement officials as required or permitted by law or in compliance with a court order or subpoena.

We may share PHI about deceased persons with medical examiners, coroners, and funeral directors;

When we believe in good faith that sharing PHI is necessary to avert a serious health or safety threat;

When sharing PHI is necessary to comply with workers' compensation laws or related purposes;

When required by state, federal or other law; we may use and share your PHI when required to do so by any other law not already referred to above.

Permissive Uses or Disclosures

We may use or share your PHI for any of the purposes described in this section unless you specifically request that we do not. Your written request must be submitted to our office.

We may contact you to remind you of an appointment.

We may contact you to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

We may share PHI about you with a friend, family member, personal representative, or any individual you identify who is involved in your care. We can tell these individuals of your condition, treatment or services. We can also give this information to someone who will help or is helping to pay for your care.

Uses and Disclosures Requiring Your Written Permission (Authorization)

Use or Disclosure with Your Permission. For any purpose other than the ones described in this notice, we may only use or share your PHI when you grant us written permission (authorization).

Marketing. We must obtain your written permission prior to using your PHI to send marketing materials. For example, we may not sell your PHI without your written authorization. We may, however, communicate with you about products or services related to your treatment, case management, care coordination, or alternative treatments, therapies, health care providers or care settings without your permission.

Revoking Your Authorization

If you give us written permission (authorization) to use or share your protected health information, you can change your mind and take back your authorization at any time, as long as you do so in writing. If you revoke your

authorization, we will no longer use or disclose the information, but we will not be able to take back any information that we have already shared.

Patient Rights with Respect to PHI

Right to Request Restrictions: You have the right to request that we restrict use or disclosure of your PHI for treatment, payment, or health care operations. With one exception, we are not required to agree to your request. If you ask us not to share your information with your health plan we will not disclose your PHI to the health plan if you pay the full cost for your care in advance.

Right to Request Confidential Communication: You have the right to request PHI in a certain form or at a specific location. Your request must be in writing. For instance, you can request that we not contact you at work, and you can tell us how and/or where you want to receive information. We will accommodate reasonable requests. If your request for confidential communication is approved, we will honor your request until you tell us in writing that you revoke the request for the confidential communication.

Right to Inspect and Copy Your Protected Health Information: You have the right to review and/or ask for a copy of your PHI, including medical records, billing records and other records. Your request must be in writing. If you request copies of information, we may charge a fee for costs associated with your request, including the cost of copies, postage or other supplies. You also have a right to an electronic copy of your information. In rare circumstances we may deny access to your protected health information. If access is denied, you can request that the denial be reviewed. Dr. Mace will review your request and make a final decision as to whether the information should be released.

Right to Request Amendment to Your Protected Health Information(PHI): You have a right to request that your PHI be amended (changed) if you believe that it is incorrect or incomplete. Your request must be in writing. You must obtain the request form from our office, submit the completed form and provide the reason that you want the amendment.

We can deny your request if: (1) it is not in writing or it does not include a reason why the information should be changed; (2) the information you want to change was not created by us; (3) the information is not part of the medical record kept by us; (4) the information is not part of the information that you are permitted to inspect or copy; or (5) the information contained in the record is accurate and complete.

Right to an Accounting of Disclosures: You have the right to receive an accounting of disclosures of medical information that we have made, with some exceptions. Your request must be in writing and must state the time period for the requested information. We will not provide this information for a time period greater than six (6) years from the date of your request.

Right to Receive a Copy of the Notice of Privacy Practices: You have the right to a paper copy of this Notice and may print a copy from our website. If you want a paper copy of this Notice mailed to you or to exercise any of your rights outlined above, please send a written request to our office.

Privacy Complaints

If you have any questions about the content of this Notice, if you believe that we have violated any of your privacy rights or did not follow the information contained in this Notice of Privacy Practices or if you have concerns about the privacy of your protected health information, please contact our office where you obtained health care services listed at the top of this Notice.

You may also file a complaint with the Office for Civil Rights ("OCR"). We will not retaliate against you for filing a complaint with us or with the OCR.

Changes to This Notice

We reserve the right to change or modify the information contained in this Notice at any time. If we change the Notice, we may make the new terms effective for all PHI that we maintain. Any changes that we make will comply with appropriate federal, state and other laws. We will make the most recent copy of this Notice available to our patients and post it in our office. You can also call or write our office to obtain the most recent version of this Notice at:

James G. Mace, D.D.S., P.C.

824 E. Sixth Street

Washington, MO 63090

636-239-7366

patientcare@smilesbymace.com

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HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient, and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand the above information and agree with its contents.

Signature:_____ **Date:**_____