Carolina Dental Specialists
Orthodontics & Periodontics
Dr. R. Bailey, Jr.

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NOTICE OF PRIVACY PRACTICES
(Consent for use and Disclosure of Health Information)

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14th, 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 changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USE AND DISCLOSURE OF HEATH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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 evoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest involving a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Release of Information: I hereby permit the practice and the physicians or other health professionals Involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment or healthcare operations. Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes.

Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specificy includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Marketing Health-Related Services: We will not use your health information for marketing communication without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters or text messages).

PATIENT RIGHTS

Access: You have the right to look 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 practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, staff time and postage if you wish mailed to you. You may also request access by sending us a letter to the address at the end of this notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

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 these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location 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 the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have question or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, please alert us by using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. 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.

Contact: Office Manager
Address: 6044 Bayfield Parkway
Concord, NC. 28027
Telephone: 704.788.1873 | Fax: 704.788.1889
Email: info@CarolinaDentalSpecialistsl.com

Right to Revoke: You have a right to revoke this Consent at any time by sending written notice of your revocation to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we have taken in reliance on this Consent before we received your revocation. Also, we may decline to treat you or to continue treating you, if you revoke this Consent.

Appointment Policy

We recognize that your time is valuable, therefore we make every effort to see you at your scheduled appointment time.

LATE ARRIVALS

If you arrive 10 minutes, or more, late then we may need to reschedule your appointment so we may have enough time to provide of the treatment that was planned for you. All appointments are pre-scheduled for certain procedures, with a predetermined amount of time.

CONFIRMING, CANCELING & RESCHEDULING

We ask that you confirm your appointments no later than *24 hours in advance of* your scheduled appointment. We send out friendly automatic text/ email/ phone reminders to confirm your appointments. Please reply to the text or email appointment reminders to confirm your appointment. Or, we welcome your phone call as well, to confirm your appointment. For scheduled surgical periodontal procedures please confirm your appointment no later than 7 days in advance, due to the longer time required & scheduled for these appointments. If you must reschedule or cancel your appointment please call us no later than 7 days in advance. If your appointment is unconfirmed, we may assume you are unable to make your appointment and may be canceled or given someone else.

Habitually canceled and/ or rescheduled appointments may be subject to dismissal from the practice. Appointments canceled in less than 24 hours notice are considered a "Broken/ Missed Appointment" and will be subject to the following ...

1st Broken/ Missed Appointment - The patient may be charged a cancellation fee ($30.00), due immediately. If a surgical periodontal appointment was scheduled, then the deposit for the procedure may be forfeited.

2nd Broken/Missed Appointment - The patient will be charged a cancellation fee ($30.00), due immediately. If a surgical periodontal appointment was scheduled, then the deposit for the procedure will be forfeited.

3rd Broken/Missed Appointment - The patient will be charged a cancellation fee ($30.00), due immediately. If a surgical periodontal appointment was scheduled, then the deposit for the procedure will be forfeited. Plus, the patient will be required to prepay prior to scheduling their next appointment and all ensuing appointments.

4th Broken/Missed Appointment - The patient will be subject to dismissal from the practice.

ORTHODONTIC APPOINTMENTS

If the patient is under the age of 18 we ask that the parents be present for the appointment. We simply don't want you to miss out on any important information that you may need to hear, see, or discuss.

We have Saturday appointments exclusively for our orthodontic patients, to accommodate your and/or your child's busy schedules. We wish we could see everyone on Saturdays, so we try to see as many of our patients as possible on Saturdays. If you break/ miss a Saturday appointment you may loose the privilege of scheduling appointments on Saturdays.

Financial Policy

PAYMENT IS DUE AT TIME OF SERVICE

For your convenience we accept cash, check, Master Card, Visa, Discover, American Express, CareCredit & CiTi Financial (both third party financing). Your insurance policy is a contract between you and your insurance company. Carolina Dental Specialists, the doctor nor staff are not involved. As a courtesy, we will be happy to bill your insurance plan(s) directly. Any co-payment and/or deductible and/or balances not covered by your insurance(s) is due at tie of service provided. Accounts past due 90 days may be subject to the services of a collection agency. No services will be rendered, other than

emergency care, until the balance is paid in full. If you become behind on your payments then please let us know. We will try our best to work with you. However, it is our policy that no appointments can be scheduled until the account is made current.

PERIODONTAL TREATMENT
The aforementioned terms apply. In scheduling periodontal surgical procedures, a minimum of 20% of the patient's financial responsibility will be collected in order to schedule appointments.

ORTHODONTIC TREATMENT
The aforementioned terms apply. Per HIPAA privacy policies, parents must check in their children, schedule their next appointment, make any payments due and stay for the beginning of the appointment in case the doctor needs to share important information.

Payment options: We offer affordable personalized payment options. For patient balances paid in full we offer an 8% courtesy discount, when paid by the start of treatment. As an alternative financing option, we offer third party financing. We also offer monthly automatic drafts from your credit card or bank account, interest free.

Delinquent payments: Orthodontic monthly payments are due on the 1st of every month until the balance due is paid in full. Payment will be considered late if it is not received by the 5th day of the month. If payment is received late, a $25.00 late fee may be assessed.

Disclosure authorization to family members and/or friends
I give permission for my health information to be disclosed for purposes of communicating appointments, results, findings and care decisions to the family members and others listed below:

Name (Relationship)	Contact Number
1._____	(_____)_____-_____
2._____	(_____)_____-_____
3._____	(_____)_____-_____

Consent to Email or Text Messaging for Appointment Reminders and Other Healthcare Communications:
As a courtesy, patients in our practice are contacted via email and/or text messaging to provide friendly appointment reminders, to confirm appointments, to obtain feedback on your experience with our healthcare team, and to provide relative health information. I understand that this consent will apply to any and all all future, updated phone numbers and email addresses. I understand I can revoke my consent by a written request. Carolina Dental Specialists does not charge for this service, but standard data/ text messaging rates may apply as outlined in your wireless plan.

_____ (initials) **I consent to receive text messages** from Carolina Dental Specialists.

_____ (initials) **I consent to receive emails** from Carolina Dental Specialists.

_____ (initials) **I decline from receiving text messages** from Carolina Dental Specialists.

_____ (initials) **I decline from receiving emails** from Carolina Dental Specialists.

I, hereby, acknowledge that I have received, read & understand the Notice of Privacy Practices, Appointment and Office Policies. I agree to comply with these policies as outlined. I also agree to allow Carolina Dental Specialists to file my insurance claim(s) on my behalf (or the patient's) as a curtsey.

_____ Date_____
Patient name (print)

_____
Signature of patient or parent/ guardian (if a minor)