MST Dental, P.C

Alan McAndrews, DMD R. Sterling Shaw, DMD Tracey Thomson, DMD

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.

Our Legal Duty

Our practice is dedicated to maintaining the privacy of your protected health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that we have in effect at that time. This Notice 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. Any revision or amendment to this notice will be in effect for all records that our practice has created or maintained in the past, and for any records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office at all times

You may request a copy of our most current notice at any time.

Uses and Disclosures of Health Information

We use and disclose health information about you for the following purposes:

Treatment: We may use or disclose your health information for treatment. For example, we may 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with the operation of our business. For example, we may use or disclose your health information to evaluate the quality of care you received, to conduct training programs, accreditation, or licensing activities. We may disclose your protected health information to other health care providers and entities to assist in their health care operations.

To You or Your Personal Representative: 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 your personal representative, but only if you agree that we may do so.

Persons Involved in Care (Family Friends): We may use or disclose health information to friends or family members that are involved in your care, or assist in taking care of you. We will use or disclose 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 to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Deceased Patients: We may use or disclose health information about a deceased patient as authorized by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances.

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

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. Your request must be made in writing and submitted to our office to look at or get copies of your health information. Our office may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.

Alternative Communication: You have the right to request that we communicate with you about your health information in a particular way or at alternative locations. Your request must be made in writing and must specify the alternative means or location where you wish to be contacted.

Restrictions: You have the right request a restriction in our use or discloser of your health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. You have the right to restrict disclosure of health information to a health plan with respect to items or services for which you have paid in full out of pocket, The request for restrictions must be made in writing.

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.

Disclosure Accounting: You have the right to receive a list of instance in which our office has disclosed your health information for purposes other than routine treatment, payment, or healthcare operations, for the last six (6) years, but not before April 14, 2003. If you are requesting this accounting more than once in a 12-month period, we may charge you a fee.

Right to a Paper Copy: You have the right to receive a paper copy of our privacy practices at any time. Please contact our office to receive your copy.

Right to File a Complaint: 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 you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized in any way for filing a complaint.

Right to Provide Authorization for Other Uses and Disclosures: In addition to our use of your health information for the above purposes, you may give us written authorization to use or disclose your health information that is not identified by this notice. Any authorization you provide us may be revoked at any time, but must be submitted in writing.

MST Dental, P.C.
4702 Misty Ridge Circle
Birmingham, Al 35235
Phone: 205-769-6238
Fax: 205-769-6245

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Tracey Thomson, DMD

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of MST Dental, P.C.'s Notice of Privacy Practices.

Print Name of Patient_____

Date of Birth_____

Signature of Patient
Or Guardian_____

Relationship to Patient_____

Date_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

____Individual refused to sign

____Communications barriers prohibited obtaining acknowledgement

____An emergency situation prevented us from obtaining acknowledgement

____Other (Please Specify)

Financial Terms and Agreement

Thank you for choosing our office for your dental needs. We realize every person's financial situation is different. For this reason we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

Dental Insurance- If you have dental benefits, congratulations, you are very fortunate. Here are some important things you should know.

- Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.
- We currently accept many insurance plans. Although we maintain computerized histories of payments by insurance companies, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.** We will also be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is **not a guarantee of coverage.** This does delay treatment but will give you the out of pocket figures you may require.
- As a courtesy our office will file your claims with most dental insurance carriers to assist you in receiving your benefits. If insurance does not pay within 60 days from the date of service, MST Dental reserves the right to request **payment in full for services from you.** Once payment is received our office will assist you in receiving reimbursement from your insurance company. We will file only with your primary dental insurance.
- **CO-PAYMENT and/or YOUR ESTIMATED PORTION OF ANY CHARGE IS DUE ON THE SAME DAY OF THE SERVICE.**

Payment Options:

- Cash, Check, Visa/Master Card, Discover
- Financing with approved credit through Wells Fargo and Care Credit. Applications available through our office.

If it becomes necessary to turn this account over for collections, I promise to pay all attorneys' fees, court costs, and all other costs of collection of my account.

Before starting any treatment with our office, we will always provide the most accurate estimate of your personal financial responsibility. Please understand that we do everything we can to ensure this estimate is as accurate as possible, but that it is based only on the information you and your insurance company have given our office. **Ultimately, you are responsible for all charges incurred in our office.**

Other Financial Terms:

- A $35.00 NSF fee will be charged for all returned checks
- A $25.00 office fee may be charged to your account unless a 24-hour notice of cancellation is given.
- Fees quoted are accepted for 90 days.
- I hereby authorize payment directly to MST Dental of the group insurance benefits otherwise payable to me

By my signature, I acknowledge that I understand the above financial policy and that I agree to comply with MST Dental's financial policy.

Patient/Parent Signature: _____ Date: _____

Print Name: _____ **PLEASE CONTINUE ON OTHER SIDE**

MST Dental, P.C. 4702 Misty Ridge Circle, Birmingham, Al 35235 205-769-6238 Fax: 205-769-6245