# HIPAA Notice of Privacy Practices

Houston, Vlosich & Short D.D.S. Inc.
3503 Soncy Rd
Amarillo, TX 79119
806.374.8011

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information**
Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. An example of this would be sending a bill for your visit to your insurance company for payment.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of our dental practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to dental school or dental hygiene students that observe patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your healthcare provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment by phone or mail.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation, research, criminal activity, military activity and national security, Workers' Compensation, inmates, required uses and disclosures, under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by law.

**You may revoke this authorization,** at any time, in writing, except to the extent that your dentist or the dental practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights**
Following is a statement of your rights with respect to your protected health information.

**Your have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your dentist amend your protected health information.**

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

| _____ | _____ | _____ |
|---|---|---|
| **Printed Name** | **Signature** | **Date** |

For more information about HIPAA or to file a complaint:
The US Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, SW
Washington, DC 20201
(202)619-0257
Toll Free: 1-877-696-6775

# HOUSTON, VLOSICH, & SHORT, D.D.S., INC.

## MEDICAL HISTORY

**PATIENT NAME** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

**PLEASE LIST**

Are you under a physician's care now? ○Yes ○No ○N/A _____

Have you ever been hospitalized or had a major operation? ○Yes ○No ○N/A _____

Have you ever had a serious head or neck injury? ○Yes ○No ○N/A _____

Are you taking any medications, pills, or drugs? ○Yes ○No ○N/A _____

Do you take, or have you taken, Phen-Fen or Redux? ○Yes ○No ○N/A Do you use tobacco? ○Yes ○No ○N/A

Are you on a special diet? ○Yes ○No ○N/A Do you use controlled substances? ○Yes ○No ○N/A

Women: Are you: ○Pregnant/Trying to get pregnant ○Nursing ○Taking oral contraceptives

Are you allergic to any of the following?

○Aspirin ○Penicillin ○Codeine ○Acrylic ○Metal ○Latex ○Local Anesthetics ○Other _____

Do you have, or have you had, any of the following?

| | | | | |
|---|---|---|---|---|
| ○AIDS/HIV Positive | ○Chest Pains | ○Frequent Headaches | ○Irregular Heartbeat | ○Scarlet Fever |
| ○Alzheimer's Disease | ○Cold Sores/Fever Blisters | ○Genital Herpes | ○Kidney Problems | ○Shingles |
| ○Anaphylaxis | ○Congenital Heart Disorder | ○Glaucoma | ○Leukemia | ○Sickle Cell Disease |
| ○Anemia | ○Convulsions | ○Hay Fever | ○Liver Disease | ○Sinus Trouble |
| ○Angina | ○Cortisone Medicine | ○Heart Attack/Failure | ○Low Blood Pressure | ○Spina Bifida |
| ○Arthritis/Gout | ○Diabetes | ○Heart Murmer* | ○Liver Disease | ○Stomach/Intestinal Disease |
| ○Artificial Heart Valve* | ○Drug Addiction | ○Heart Pace Maker* | ○Mitro Valve Prolapse* | ○Stroke |
| ○Artificial Joint* | ○Easily Winded | ○Heart Trouble/Disease | ○Pain in Jaw Joints | ○Swelling of Limbs |
| ○Asthma | ○Emphysema | ○Hemophilia | ○Parathyroid Disease | ○Thyroid Disease |
| ○Blood Disease | ○Epilepsy or Seizures | ○Hepatitis A | ○Psychiatric Care | ○Tonsillitis |
| ○Blood Transfusion | ○Excessive Bleeding | ○ Hepatitis B or C | ○Radiation Treatments | ○Tuberculosis |
| ○Breathing Problem | ○ Excessive Thirst | ○Herpes | ○Recent Weight Loss | ○Tumors or Growths |
| ○Bruise Easily | ○Fainting Spells/Dizziness | ○High Blood Pressure | ○Renal Dialysis | ○Ulcers |
| ○Cancer | ○Frequent Cough | ○Hives or Rash | ○Rheumatic Fever* | ○Venereal Disease |
| ○Chemotherapy | ○Frequent Diarrhea | ○Hypoglycemia | ○Rheumatism | ○Yellow Jaundice |

Have you ever had any serious illness not listed above? ○Yes ○No ○N/A _____

Comments: _____

_____

_____

*Condition my require medication

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

# HOUSTON, VLOSICH, & SHORT, D.D.S., INC.
# 3503 S SONCY
# AMARILLO, TX 79119

**PATIENT INFORMATION**

FIRST NAME:_____LAST NAME:_____

ADDRESS:_____

CITY: _____STATE:_____ZIP:_____

HOME PHONE:_____WORK PHONE:_____CELL:_____

EMERGENCY CONTACT NAME & NUMBER:_____

_____

IF PATIENT IS UNDER 18 YRS OLD, LIST PARENTS NAMES & CONTACT #'S:_____

_____

SEX: MALE FEMALE
(CIRCLE ONE)

MARITAL STATUS: SINGLE MARRIED DIVORCED SEPERATED WIDOWED
(CIRCLE ONE)

BIRTHDATE:_____AGE:_____SS#:_____DL#:_____

**RESPONSIBLE PARTY INFORMATION (IF SOMEONE OTHER THAN PATIENT)**

FIRST NAME:_____LAST NAME:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____WORK PHONE:_____CELL:_____

BIRTHDATE:_____AGE:_____SS#:_____DL#:_____

**PRIMARY DENTAL INSURANCE INFORMATION (COPY OF CARD REQUIRED FOR US TO FILE)**

EMPLOYEE NAME:_____EMPLOYEE SS#:_____

EMPLOYER NAME:_____DOB OF EMPLOYEE:_____

INSURANCE COMPANY NAME:_____

**SIGN YOUR NAME** **DATE**

_____ _____