Morrison Dental Group 

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 12/20/2016, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY SEND HEALTH INFORMATION ABOUT YOU

Your protected health information ("PHI") includes information relating to your mental or physical health and to the health care provided to you, including materials like your dental records, dental x-rays, and payment records. Some documents containing PHI may include such sensitive personal information as a Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse records, positive HIV status, and other kinds of sensitive information.

Sometimes our dental practice needs to send PHI to the patient or to someone else, such as a specialist. There are various ways to send PHI, including email and other electronic means. Our dental practice uses a HIPPA compliant email server for electronic forms of communication.

Should information be sent unencrypted for any reason, there is a risk that the information may be acquired by hackers or received by unintended recipients. If you are concerned about the security of PHI that may be sent unencrypted, please let us know and we will send it a different way, which may include providing the information to you to deliver.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations.

Treatment. We may disclose your health information to a specialist providing treatment to you.

Payment. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. Healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your 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 Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;

- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure

is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if 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, you may complain to us 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 will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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.

Our Privacy Official: Alison Morrison

Telephone: (757) 258-7778 Fax: (757) 258-5185

Address: 7151 Richmond Rd., Suite 305, Williamsburg, VA 23188

E-mail: info@morrisondentalgroup.com

Morrison Dental Group

MORRISON DENTAL GROUP

Patient Registration Form

PATIENT INFORMATION: Date: _____

Chart#: _____ Email for Appointment Reminders: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

Mailing Address (If Different): _____ Apt#: _____ City: _____ State: _____ Zip: _____

SS#: _____ Home Phone: _____ Work Phone: _____ Cell: _____

Sex: Male ☐ Female ☐ Marital Status: S ☐ M ☐ D ☐ W ☐ Date of Birth: _____ Age: _____

Occupation: _____ If Student, School: _____

Employer: _____ Address: _____ Phone: _____

Spouse's Name: _____ SS#: _____ Employer: _____

How do you prefer to be contacted for appointment reminders?

(Please check all that apply): Text me! ☐ Call me! ☐ Email me! ☐ On Website! ☐

I was referred to this practice by: _____

RESPONSIBLE PARTY (if different from the patient):

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

SS#: _____ Date of Birth: _____ Relationship to Patient: Spouse ☐ Parent ☐ Other ☐ _____

Home Phone: _____ Work Phone: _____ Occupation: _____

Employer: _____ Address: _____ Phone: _____

PRIMARY INSURANCE INFORMATION:

Insurance Company Name: _____ Phone#: _____

Claims Address: _____

Policy ID#: _____ Group#: _____ Plan#: _____

Policyholder's Name: _____ SS#: _____

Date of Birth: _____ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐ _____

Employer: _____ Address: _____ Phone: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company Name: _____ Phone#: _____

Claims Address: _____

Policy ID#: _____ Group#: _____ Plan#: _____

Policyholder's Name: _____ SS#: _____

Date of Birth: _____ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐ _____

Employer: _____ Address: _____ Phone: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

— You May Refuse to Sign This Acknowledgement —

I, _____, have reviewed a copy of this office's Notice of Privacy Practices.

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (Check boxes that apply):

- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Latex Allergy
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Alzheimers
- ☐ Dementia
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Mitral Valve Prolapse
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Blood Thinners
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ AIDS/HIV
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____

If so, what? _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what? _____

_____

Are you under the care of a physician? ☐ Yes ☐ No

For what conditions? _____

If patient is a child, what is his/her weight? _____

(Woman) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

Do you have x-rays at another dental practice? _____

MORRISON DENTAL GROUP

1131 Professional Drive	7151 Richmond Road Ste. 305	1130 Wilkinson Road	4009 Main Street	710 Denbigh Blvd., Bldg. 1, Suite C
Williamsburg, VA 23185	Williamsburg, VA 23188	Richmond, VA 23227	Chincoteague, VA 23336	Newport News, VA 23608
(T) 757-220-0330	(T) 757-258-7778	(T) 804-261-4020	(T) 757-336-1260	(T) 757-874-5511
(F) 757-220-9067	(F) 757-258-5185	(F) 804-261-6839	(F) 757-336-1262	(F) 757-716-4371

WELCOME TO THE OFFICE

Our staff appreciates the selection of this office to service your dental health needs. Our goal in this practice is to provide the very best possible dental care for our patients so that each of you may enjoy optimal dental health throughout your lifetime.

During your first visit a thorough examination will be completed. This will include x-rays or other aids that are necessary in making an accurate diagnosis. We will determine and discuss your dental treatment with you, not for you.

Except for emergency situations, you can expect us to be on time for your appointment and we appreciate the same courtesy. No charge will be made for rescheduling your appointment, provided 24 hours notice is given so that your time can be given to another patient.

PATIENT/FAMILY BEHAVIOR

While in a Morrison Dental Group office or facility, I will be polite to the staff. I will be polite to all medical providers. I will be polite to other patients.

MORRISON DENTAL GROUP IS NOT RESPONSIBLE FOR LOSS OF PERSONAL BELONGINGS

Morrison Dental Group is not responsible for any loss, theft or damage to my personal belongings.

FINANCIAL POLICY

To avoid any misunderstandings concerning fees, you may receive an **estimate** of the proposed services prior to treatment. We require payment at the time of service. Our goal is to provide you with the best care possible and we strongly believe that a clear understanding of your financial responsibilities is vital to a healthy relationship with our practice. To assist you in this, several payment options are available for your convenience.

1. *PAYMENTS DUE AT TIME OF SERVICE*: Morrison Dental Group will bill most insurance companies for patients, even though they do not have to do so. If my insurance company does not pay all or part of my bill, I will pay. Full payment is due at time of service. I will be charged $25 for any returned checks. I give permission to Morrison Dental Group to apply any overpayment from another Morrison Dental Group account to any other bill that I may owe.
2. VISA and MASTERCARD.
3. CareCredit
4. Compassionate Finance

After 60 days a 1.5% finance charge will be applied to the unpaid balance on your account. This includes unpaid insurance claims. In the event this account is referred for legal action, the patient agrees to pay the cost of court, collection and 25% attorney fees.

DENTAL INSURANCE

Please understand that your insurance policy is an arrangement made between you and your carrier. To avoid any confusion **please make sure your insurance company will allow you to visit us**. Our practice deals with many different insurance plans and thus cannot guarantee that a certain amount of any charge will be covered. Health plans differ and can often cover the same services at different payment schedules. The best way to proceed is to be in contact with your insurance company and understand the details of your plan coverage. We will provide codes for dental services which you can then give to your provider to learn about your coverage and payments.

PRE-ESTIMATES AND TREATMENT PLANS

They are **NOT** final invoices nor do they represent full patient responsibility. Your insurance plan may have exclusions for services, deductibles, patient co-pays, maximum annual coverage amount, and/or waiting periods. A pre-estimate may be sent to your insurance company as a courtesy. It does not constitute full and final payment for any treatment you schedule with our office.

CO-PAYMENTS, DEDUCTIBLES, AND AMOUNTS NOT COVERED BY YOUR INSURANCE ARE YOUR RESPONSIBILITY

We collect a co-pay at the time of service. Please note that due to our own contracts with insurance companies **we are unable to waive co-payments or deductibles**. Our practice must accept negotiated charges with some insurance carriers due to existing contracts; however this is not applicable to all insurance companies. Therefore, it is possible that what your insurance carrier deems "customary" and what we charge does not match up. In those cases, the balance is your responsibility unless your insurance company instructs us to write off the difference.

IF YOU HAVE NO DENTAL INSURANCE YOU ARE RESPONSIBLE FOR THE ENTIRETY OF YOUR BALANCE

If you cannot pay off the balance in full at the time of your visit, please speak with our office coordinator to discuss CareCredit, or Compassionate Finance.

_____	_____	_____
Signature	Print Name	Date

Morrison Dental Group

CONSENT TO RELEASE CONFIDENTIAL HEALTH CARE INFORMATION

Patient Name: _____ Date: _____

Current Dental Provider's Name:_____
Provider

Address: _____
Provider

Fax Number: _____ Phone Number: _____
Provider *Provider*

Please disclose all health information and send records to*:
(Patient: Please mark the location of your first Morrison Dental Group Appointment)

☐	☐	☐	☐	☐
7151 Richmond Rd., Suite 305 Williamsburg, VA 23188 Phone: (757) 258-7778 FAX: (757) 258-5158	1131 Professional Drive Williamsburg, VA 23185 Phone: (757) 220-0330 FAX: (757) 220-9067	4009 Main Street Chincoteague, VA 23336 Phone: (757) 336-1260 FAX: (757) 336-1262	710 Denbigh Blvd. Bldg. 1, Suite C Newport News, VA 23608 Phone: (757) 874-5511 FAX: (757) 716-4731	1130 Wilkinson Rd. Richmond, VA 23227 Phone: (804) 261-4020 FAX: (804) 261-6839

****Provider:* Please send information to the office that is checked above, or e-mail us at**

records@morrisondentalgroupva.com

***Patient:* Please submit this form to your current dental healthcare provider's office.**

As the person signing this consent, I understand that I am giving my permission to the above named provider for disclosure of confidential health care records.

☐ No I do not have x-rays at any other provider.

Signature of Patient: _____ Date: _____

Internal use only:
Chart #: _____

Morrison Dental Group

HIPAA Notice of Privacy Practices
Acknowledgement of Receipt

Morrison Dental Group will use and disclose your personal health information to treat you, to receive payment for care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. The financially responsible party, if it is not me, has the right to discuss my account balance. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regard to protected health information. The terms of this notice may change with time, and we will post the current notice at our facility and have copies available for distribution.

I also give **Morrison Dental Group** permission to speak to the following people (if any) regarding my health information:

_____ _____

_____ _____

I hereby acknowledge that I have read and received a copy of Morrison Dental Groups HIPAA Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____ Telephone:_____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary of personal representative of deceased patient

Name of Patient: _____

FOR OFFICE USE ONLY:
Signed form received by: _____

Acknowledgement refused: _____
Reason for refusal:

Morrison Dental Group

Preferred Method of Contact

Morrison Dental Group would like to contact you via your preferred method regarding appointment reminders, scheduling changes, etc. Please complete the following so that we can reach you via the best method.

Name:_____

☐ Phone call to house phone ☐ Text to cell phone ☐ E-mail notification

Please include your number: _____

Is this your home/cell number: _____

Please include your e-mail address: _____

Please remember to "confirm**" when you receive your reminder, or the calls/texts/e-mails will keep coming!**

Anything you want to change about your smile? Let us know! _____

_____