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.

Robert A. Witer DDS Inc
(Name of Dental Practice)

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as California privacy laws, we are required to maintain the privacy and security of your health information. We are also required to post in a clear and prominent location, and provide patients with this Notice of Privacy Practices, which details our privacy practices, our legal duties, and your rights concerning your health information. This Notice is currently in effect, 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 law. If changes are made, a new Notice of Privacy Practices will be displayed in our office and will be 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following describes how information about you may be used in this dental office:

- **Treatment Services:** We may use or disclose your health information to a physician or other health care provider providing treatment to you.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you. Upon your written request, we will not disclose to your health insurer any services paid by you out of pocket.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations, which include quality assurance, disease management, training, licensing, and certification programs.
- **Other Authorizations:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke 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.
- **Family Members, Friends, and Others Involved in Care:** Only if you agree that we may do so, we may disclose your health information to a family member, friend, or other person if necessary to assist with your treatment and/or payment for services. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to sue uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information that is directly relevant to the person's involvement in your healthcare. Your information may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location, condition, or death.
- **Marketing/Fundraising:** We will not use your health information for marketing or fundraising purposes without your written consent. You can opt out of receiving information about our marketing or fundraisers. We will not sell your health information without your explicit authorization.

- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, postcards, or letters. We will use unencrypted email for communicating with you at your specific request only.
- **Legal Requirements:** We may disclose your health information when required to do so by law.
- **Abuse or Neglect:** If abuse, neglect, or domestic violence is reasonably suspected, we may use or disclose your health information to the appropriate authorities to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- **National Security:** When required, we may disclose to military authorities the health information of Armed Forces personnel. Information may be given to authorized federal officials when required for intelligence, counterintelligence, and national security activities. Under certain circumstances, we may disclose health information of inmate(s) to correctional institutions or law enforcement officials having lawful custody of the inmate(s).
- **Business Associates:** Some services in our organization are provided through contacts with business associates. Examples include practice management software representatives, accountants, answering service personnel, etc. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. All of our business associates are required to safeguard your information and to follow HIPAA Privacy Rules.
- **Public Health Activities:** We may disclose medical information for public health activities, to include the following: to prevent or control disease, injury, or disability; to report reactions with medications or problems with products, to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease of condition.
- **Breach Notification:** We will notify you any time your PHI may have been compromised through unauthorized acquisition, access, use or disclosure.

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.

  We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request x-Rays, there will be a fee for any copies of films. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Details of all fees are available from the HIPAA Coordinator.
- **Accounting of Disclosures:** 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. 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 will keep your information confidential from your health plans if you pay in cash, at your request. In some instances, we may not be 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 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 must explain the reason for the amendment.) We may deny your request under certain circumstances.

- **Electronic Notice:** If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy policy or have questions or concerns, please contact us. If you have concerns relating to a perceived violation of your privacy rights, to access to your health information, to amending or restricting the use or disclosure of your health information, or to requesting alternative means of communication, you may contact us using the contact information listed at the end of this Notice. You also may submit a written complaint to the Department of Health and Human Services (HHS). We will provide you with the HHS address 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 HHS.

HIPAA Coordinator: Dr Robert A Witek

Telephone: 951-302-9800 Fax: 951-302-6012

Email: rwitek5@yahoo.com

Address: 31309 Temecula Parkway Ste 100 Temecula CA 92592

PATIENT ACKNOWLEDGEMENT OF RECEIPT Of NOTICE OF PRIVACY PRACTICES - SAMPLE

By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment, and health care operation purposes.

I hereby acknowledge that I have received from Robert A. Witek DDS Inc a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how my personal health information may be used and/or disclosed both with and without my authorization. I further understand that I may contact the HIPAA Coordinator if I have any questions regarding the contents of this Notice of Privacy Practices or to file a complaint about the privacy practices.

Signature: ______________________________

Patient Name: ______________________________

Patient Representative (if minor): ______________________________

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________________ Date: ______________ ______________

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ____________________ E-mail: ____________________

Patient #: ____________________ Social Security #: ____________________

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Robert A Witek D.D.S. Inc
31309 Temecula Parkway Ste 109
Temecula, CA 92592
Phone (951) 302-9800   fax (951) 302-9800

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

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ____________________ Date: ____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

CROWNS - CAPS

BENEFITS

Make you look nicer (cosmetic)

To prevent a tooth from fracturing
To restore a tooth which has broken
To eliminate a space where food is being trapped
To hold a false tooth in place as part of a bridge
To make a solid structure to attach a partial denture
To splint loose teeth together to strengthen them
The tooth no longer can be filled (filling to large to last)

POSSIBLE COMPLICATIONS

Porcelain portion of crown may fracture
Crown may come off and need to be recemented
Tooth may abscess and require further treatment (may not show up until later due to deep decay)
Future decay may require a filling or new crown

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING

Tooth will probably fracture
Tooth may need to be extracted
May need a root canal in addition to the crown
May need bridgework or dentures

ALTERNATIVES

Extraction
Temporary crown
Steel crown

BRIDGEWORK

BENEFITS

Make you look nicer
To replace missing teeth
Missing teeth are not removable
Some of same advantages as Crowns
Can improve chewing efficiently
Keep missing teeth form drifting

POSSIBLE COMPLICATIONS

Same as Crowns

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING

Teeth will drift and lean over
May lose back teeth due to shifting
Periodontal problems (gum disease)
Can reduce chewing efficiency

ALTERNATIVES

Partials
Temporary partials
No teeth in the spaces

IMMEDIATE DENTURES

POSSIBLE COMPLICATIONS

Immediate Denture do require 2 soft relines
Hard reline 6 to 8 months after surgery
Full lower dentures if loose requires implants

PARTIALS (REMOVABLE BRIDGEWORK)

BENEFITS (less than fixed bridge)

Cost

POSSIBLE COMPLICATIONS

Can wear on teeth
Can rock or stress teeth - may loosen own natural teeth
Metal clasps are sometimes visible
Decay can occur under clasps
Usually some amount of movement from the partial

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING

Same as under Bridgework

ALTERNATIVES

Bridgework
Temporary partial
Keep spaces without teeth placement

ROOT CANAL

BENEFITS

Eliminate infection
Relieve pain
Save the tooth from extraction

POSSIBLE COMPLICATIONS

Undiagnosable root fracture means failure and extractions
Undiagnosable auxiliary canal means failure and extraction
Infection

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING

Extraction of tooth
Serious infection

ALTERNATIVES

Extraction
Bridgework
Partial Denture

GUM SURGERY (GINGIVECTOMY)

BENEFITS

Eliminate infection
Reduce food pockets around teeth
Eliminate foul odors
Reduce overgrown tissue
Can eliminate tartar effectively

POSSIBLE COMPLICATIONS

May need to be repeated after a time
Some after pain
Might lose teeth if they don't respond to treatment

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING

Will lose teeth sooner
May not get rid of infection

ALTERNATIVES

More frequent appointments for scaling

NAME OF PATIENT: ______________________

NAME OF GUARDIAN: ______________________

I HAVE READ THE ABOVE STATEMENTS AND HAVE RECEIVED A COPY OF THEM, RECOGNIZE AND UNDERSTAND THEIR IMPORTANCE IN HELPING ME MAKE DECISIONS. I RECOGNIZE AND UNDERSTAND THAT FAILURES CAN OCCUR FOR VARIOUS REASONS AND THAT COMPLICATIONS CAN OCCUR IN ANY PROCEDURE. I ALSO UNDERSTAND THAT WHERE DECAY HAS OCCURRED, OR A TOOTH HAS FRACTURED OR ABSCESSED, THESE SAME FORCES ARE STILL WORKING ON THE TOOTH EVEN AFTER IS HAS BEEN RESTORED; THEREFORE, DECAY OR FRACTURE CAN STILL OCCUR AS THE RESTORED TOOTH IS NO BETTER THAN WHAT NATURE HAS GIVEN IN THE FIRST PLACE. IN ORDER TO RECEIVE TREATMENT, I CONTRACT THAT IF THERE IS ANY DIFFERENCES OR DISAGREEMENTS BETWEEN MY ATTENDING DENTIST AND MYSELF, I WILL FIRST PRESENT SUCH DIFFERENCE OR DISAGREEMENT TO MY ATTENDING DENTIST IN ORDER TO RESOLVE THE PROBLEM. IF WE ARE UNABLE TO AGREE ON A SOLUTION, THEN I AGREE TO TAKE THE PROBLEM TO A RECONCILIATION BOARD SUCH AS THE DENTAL SOCIETY OF CALIFORNIA STATE CONSUMER AFFAIRS BOARD OF DENTAL EXAMINERS AND AGREE TO ACCEPT THEIR RESOLUTION IN LIEU OF PURSUING REMEDIES BY WAY OF LITIGATION. IN CONSIDERATION OF HELPING TO KEEP COSTS OF TREATMENT AND SERVICES AS LOW AS POSSIBLE, I ALSO UNDERSTAND THAT THIS AGREEMENT IS BINDING ON MY HEIRS AND ALL OTHER FAMILY MEMBERS.

______________________ ______________________

ARBITRATION AGREEMENT

Article 1: AGREEMENT TO ARBITRATE

I understand that any dispute as to dental malpractice, that is as to whether any dental care and treatment rendered to patient under this agreement were unnecessary or unauthorized, or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by [insert "State"] law, and not by lawsuit or resort to court process except as [insert "State"] law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article II: ALL CLAIMS MUST BE ARBITRATED

It is the intent of the parties that this agreement binds all parties whose claims may arise out of or related to treatment or services provided by the dentist, partners, associates and agents or employees, including any spouse or heirs of the patient, born or unborN, at the time of the occurrence giving rise to any claim.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the dentist, partners, associates, and employees or agents, must be arbitrated, including, without limitation, claims for lost of consortium, wrongful deatk emotional distress punitive damages. filling, of any action in any court by the dentist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against, the dentist, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article III: PROCEDURES AND APPLICABLE LAW

A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty (30) days and third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed to the parties within thirty (30) days thereafter. Each party to the arbitrator shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to arbitrate the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or any entity which would otherwis by a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additiona person or entity shall be stayed pending arbitration.

The parties agree that provisions of (insert "State") law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, [insert appropriate state laws by Code & Section number.]

Article IV: GENERAL PROVISIONS

All claims based upon the same Incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted as a civil action, would be barred by the applicable California statute of limitations or (2) the claimant falls to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the [insert "State") Code of Civil Procedure provision relating to arbitration.

Article V: REVOCATION

This agreement way be revoked by written notice delivered within thirty (30) days of signature and if not revoked will govern all dental services received by the patient.

Article VI: RETROACTIVE EFFECT

If patient intend this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial below:

Effective as of the date of first medical services. ________ Pt. Initials

If any provision of this Arbitration Agreement -is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING AGREEMENT YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP ACCESS TO A JURY OR COURT TRIAL. See Article I of this.

____
Print name of Dentist. Dental Group, Association

ROBERT A. WITEK, D.D.S., INC.

By: ________________________________
Dentist of Duty — Date
Authorized Represenative

____
Patient Signature — Date

____
Patient Printed Name

Translated by: (if applicable)

____
Signature — Date

____
Print Name

____
Patient's Agent or Representative — Date

*If patient is under 18 years of age a parent or legal guardian must sign

____
Print Name

____
Relationship to Patient

A signed copy of this document is given to the patient.
Original to be filed in patient's chart.

Creating Smiles
Robert A. Witek, DDS., Inc.

Robert A Witek D.D.S. Inc
31309 Temecula Parkway Ste 109
Temecula, CA 92592

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
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 the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

____

Creating Smiles Dental Office
Robert A. Witek, D.D.S., Inc

Payment Policy

Full payment for service rendered is expected at the time services are provided for all cash and non-insured patients. Co-payment and deductibles are also due at the time services are provided for those insured patients.

We will do our best in getting your benefits and co-payment information from your insurance company; however, we are relying on insurance information given to us over the phone and per the insurance company quotes, "this is not a guarantee of payment" from them.

You will be billed for any amount not paid by your insurance company. We will send you a statement as soon as possible, but keep in mind it takes 2-4 months (or longer) to get payment from your insurance company.

If you need to make payment arrangements please do so prior to your treatment being done. Our office accepts cash, checks, Visa, Master Card, Discover, Care Credit and Health Care Credit.

We can help you apply for Care Credit and Health Care Credit right here in our office.

By submitting your check for payment, you are authorizing the payee, or its agent, upon receipt of your check, to convert the check to an electronic payment item or draft and to submit it for payment as an ACH debit entry or draft to your account, in accordance with the same terms and conditions as your check.

Cancellation Policy

This office requires 24hr notice if you have to cancel or reschedule any appointment. Failure to do so may result in a $50 charge on your account. This fee is not covered by your insurance.

I understand the policies of the office.

_______________________________ ______________________________

Signature of Patient Date