

**BEACON SQUARE FAMILY DENTISTRY**  
7805 Beacon Square Blvd Suite 101  
Boca Raton, FL 33487 (561) 998-0901

**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.**

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**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 March 1, 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 all 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.

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**USES AND DISCLOSURES OF HEALTH 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 or disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use or 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 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 can not 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 in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications 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.

**National Security:** We may disclose your health information to military authorities of the armed forces under certain circumstances. We may disclose to authorized federal authorities/officials health information required for lawful intelligence, counter-intelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

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

## **PATIENT RIGHTS**

**Access:** You have the right to view 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 can not 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 and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies we will charge you .99 cents for each page, \$ n/a per hour for staff time to locate and copy your health care information, and postage if you want copies mailed to you. 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. Duplication of x-rays are \$25.00.

**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 5 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. Shapiro Family Dentistry has adopted an office policy due to the extensive amount of time and paperwork involved in insurance billing. Shapiro Family Dentistry will continue to submit claims as a courtesy, however, if we fail to receive payment within 30 days from your insurance company, we will then bill you directly including collection costs if applicable. Payment will be due 14 days from the date of your statement. Due to Florida requirements regarding disposal of biomedical waste and the costs required to comply with this requirement our office charges an infection control fee to cover the necessary time, paperwork and costs to comply with this Statute including removal of biomedical waste for the protection of our patients. We will invoice your insurance company accordingly. Some insurance companies request invoicing for crowns (2750/6750 and other dental procedures associated with laboratory fees), on insertion dates, some (Cigna) on

preparation dates, and some (Metlife) plans on insertion or preparation depending on the plan. In light of the above, and the difficulty ascertaining which date to use, this office will unilaterally invoice your insurance company on the preparation date as this is the date the laboratory fee is incurred. If you do not have insurance we will invoice you on day of impressions for any laboratory work. We adhere to all fee schedules as a contracted provider for insurance plans and you must understand that your carrier may pay less than the actual amount submitted. You agree to be responsible for payment of all services rendered on your behalf and on the behalf of your dependents and agree by your signature below that you assign all insurance benefits to Shapiro Family Dentistry, if any, otherwise payable to me for services rendered, and that you authorize your signature on all insurance submissions on your behalf. I further authorize Shapiro Family Dentistry to charge my credit card for any deficiency after payment from my insurance company.

**Administrative Fee:** Section 466 of the Florida Statutes requires that “**patient records kept in accordance with this section shall be maintained for a period of 4 years from the date of the patient's last appointment.**” This office **charges an administration fee** which covers the necessary time, paperwork, and storage facilities, to comply with this Statute and the operation of this facility including the preparation and furnishing of all paperwork necessary under provisions of the statute and applications for licensing to operate radiographic equipment (x-rays), renewal and payment of all licenses, state, county and city fees, and required reports and credentialing requirements for the operation and continued compliance of this dental office, and/or removal of biohazardous waste, and infection control, and sterilization monitoring and the increased cost of dental products due to the **new Federal Excise Tax**. Should any patient wish to review the results of our sterilization monitoring tests please call Dr.Mike at 561-998-0901 and he will make them available to you. This fee is charged on **EACH APPOINTMENT**.

**I have read and understand the above Administrative Fee.** \_\_\_\_\_  
Your signature

**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 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 it must specify why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

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**QUESTIONS AND COMPLAINTS** If you want more information about our privacy practices or have any questions 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, you may complain to us using the contact information listed at the end of this Notice. You 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 privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer: Dr.Mike  
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Facsimile: 561-998-0903  
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