NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are properly kept confidential. HIPAA gives you, the patient, significant rights to understand and control how your health information is used.

HIPAA provides penalties for covered entities, including our Practice, that misuse “protected health information” (PHI). PHI 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. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

You may request a copy of our current Notice of Privacy Practices at any time. For more information about our practices, or for additional copies, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your PHI 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, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office, or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends, and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your care. If you are present, prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death, or in emergency circumstances, if deemed appropriate based upon our

professional judgment, we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. 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 obtain prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we may disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities. Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to

a third party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a sale of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI 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. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We will notify you of a breach of your unsecured PHI, as required by HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and

other permitted uses as described in this Notice of Privacy Practices, for the last 3 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 the additional requests. You have the right to request such an accounting in an electronic format.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency circumstances.

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request, in writing, that we amend your PHI. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Tulane Family Dentistry
2504 Tulane Ave
New Orleans, LA 70119
(504) 304-9929

Authorization

General Consent to Treatment: I agree and consent to a dental examination by the doctors at Tulane Family Dentistry. I understand that additional diagnostic procedures and treatment may be recommended by the dentist and will be discussed with me before being done. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatment.

Release of Information: I authorize dentists providing services on behalf of the patient to release all billing and medical information to patient's insurance carrier, employer, person(s) acting on behalf of a preferred provider arrangement or a third party named on the patient information form, when such information is requested. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to this office. A copy of our privacy practices has been provided to you and details your protected health information rights.

Assignment of Insurance of Third Party Coverage: I authorize any third party payer to pay directly to the dentist providing services to the patient. All benefits due are due payable as a result of services rendered.

I authorize assignment to the dentist providing services to the patient that the insured's rights to penalties and attorney's fees in the event that the insurer fails to timely pay such benefits in accordance with Louisiana Law (LA R.S. 22:657)

Acknowledgement of Responsibility to Pay for Services: I acknowledge and agree that, except as provided by law, and in consideration of the services provided, I will pay any charges which, for any reason, are not paid by any third party payer. I acknowledge that this fee is incurred on an open account for professional dental services, in accordance with R.S. 9:2781. I acknowledge that if I fail to pay the balance due on this open account within thirty days after written demand, and in the event judgment is rendered against me, in addition to the principal balance due, I shall be liable for reasonable attorney fees, legal interest from date of judicial demand, until paid, plus costs of court.

_____

Signature of Patient, Parent/Guardian

_____

Relationship to Patient (if child is a minor)

_____

Date

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided a copy of Tulane Family Dentistry's Notice of Privacy Practices, which describes how my personal health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

I understand that I have the right to revoke this consent at any time by giving Tulane Family Dentistry a written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance of this consent before we received your revocation, and that we may decline to treat you or continue treating you.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____

Signature of Patient or Patient's Representative

_____

Date

_____

Print Name

_____

Relationship to Patient (If not signed by the Patient)

BROKEN APPOINTMENT POLICY

We would like to thank you for choosing to be a patient in our office. We value all of our patients and strive to provide the best dental care possible in the most comfortable setting. We know your time is valuable and we aim to honor your appointment time; however there are times when our schedule is delayed in order to accommodate an emergency or complication in a scheduled procedure. Please accept our apology should this occur during your appointment and know we will do our best to notify you of any delays in your treatment time.

We realize that illness, emergencies and changes in work or school schedules occasionally occur. We kindly ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved time to another patient who needs it.

It is our policy to obtain a $50 deposit when rescheduling a broken appointment. A broken appointment is when you cancel or reschedule an appointment with less than 24 hour notice or do not show up for the scheduled appointment. Repeated broken appointments could result in the refusal of any further appointments with our office.

Our office does ask patients to confirm their appointments. We have many different ways that your appointment can be confirmed, including phone calls, emails and text. Please let us know your preferred method of communication with us.

Thank you very much for your cooperation and understanding. We appreciate your mutual respect of everyone's time. Your dental health is very important and we take our job of helping you keep your teeth for a lifetime seriously.

_____

Printed Name of Responsible Party

_____ _____

Signature of Responsible Party Date

PATIENT REGISTRATION AND MEDICAL HISTORY
(PLEASE PRINT)

DATE _____

PATIENT _____
Last Name First Name MI

ADDRESS _____
Street City State Zip

HOME #: _____ CELL #: _____WORK #: _____

SEX: ☐M ☐F AGE: _____ BIRTHDATE: _____ ☐Single ☐Married ☐Child

Employer:_____ Occupation: _____

Email: _____ Student: Full Time Part Time

Social Security #: _____ Spouse/Parent Social Security #: _____

Spouse/Parent Name: _____ Spouse/Parent Birthdate: _____

Spouse/Parent Employer: _____ Occupation: _____

Employer Address: _____ Employer Phone: _____

Person Responsible for this Account: ☐SELF ☐SPOUSE ☐PARENT ☐GUARDIAN ☐OTHER

Dental Insurance: _____ Group #: _____

Emergency Contact: _____ Phone #: _____

How did you hear about us? ☐Internet ☐Health Fair ☐Other, please explain_____

☐Referred, whom may we thank for referring you? _____

Reason for Today's Visit: _____ Date of last dental visit: _____

Dentist's Name: _____ What was done: _____

Medical History

Do you have or have you ever had any of the following? (check all that apply)

☐Heart Problems	☐Epilepsy	☐Special Diet	☐Stroke
☐High Blood Pressure	☐Headaches/Migranes	☐Swollen Neck Glands	☐Ulcer
☐Low Blood Pressure	☐Hepatitis, jaundice or liver disease	☐Rheumatic Fever	☐Diabetes
☐Circulatory Problems	☐Immunosuppressive Disorder	☐Sinus Problems	
☐Cancer			
☐Nervous Problems	☐Artificial Heart Valves/Joints	☐Radiation Treatment	☐Arthritis
☐Weight Loss	☐Psychiatric Care	☐Chronic Diarrhea	☐Hemophilia
☐Back Problems	☐Respiratory disease/asthma	☐Allergies	☐Smoker
☐Chemical Dependency	☐Venereal disease	☐HIV	

Do you have any drug allergies or have you had an adverse reaction to any medication? _____ if yes, to what _____

Have you responded negatively to medical or dental treatment? _____

Are you taking any medications at this time? _____ if yes, what? _____

Are you currently under the care of a physician? _____

Physician's Name: _____ Physician phone #: _____

Date of Last Physical:_____

f yes, for what condition(s)?_____

Are you Pregnant? ☐YES ☐NO Due Date _____ Nursing? ☐YES ☐NO Birth Control? ☐YES ☐NO

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

The above information is accurate and complete to the best of my knowledge and is only for use in the treatment, billing, and processing of insurance for benefits for which myself or my child is 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: _____

Relationship to patient (if patient is a minor): _____

Minor/Child Consent

I, being the parent or guardian of _____ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays and the administration of anesthetics which are deemed advisable by the doctors at Tulane Family Dentistry, whether or not I am present at the appointment when the treatment is rendered.

Date: _____ Signature of Parent/Guardian: _____

Tulane Family Dentistry
2504 Tulane Ave
New Orleans, LA 70119
P. 504-304-9929 • F. 504-304-6517
www.tfdnola.com

Dr. William J. Shelton, D.D.S.
Dr. Alexis L. Russell, D.D.S.

TULANE FAMILY DENTISTRY PICTURE RELEASE FORM

For valuable consideration, receipt of which is hereby acknowledged, I agree as follows:

1. I hereby give and grant William J. Shelton, DDS, Alexis L. Russell, DDS and Tulane Family Dentistry, LLC, for unlimited period of time (the "Term"), the right to use, publish, copyright, broadcast, reproduce, reuse, republish, or shorten for purposes of copy, my name, picture, portrait, likeness, and testimonial statement, throughout the world, in any and all media and types of advertising and promotion now known.
2. I agree that all photographs of me used and taken by William J. Shelton, DDS, Alexis L. Russell, DDS and Your LifeSmiles are owned by them and that they may copyright material containing the same. If I should receive any print, negative or other copy thereof, I shall not authorize its use by anyone else.
3. I agree that no advertisement or other material need to be submitted to me for approval and William J. Shelton, DDS, Alexis L. Russell, DDS and Your LifeSmiles shall be without liability to me for any distortion or illusionary effect resulting from the publication of my picture.
4. I represent that the following or attached testimonial statement is true and accurate. I further agree that the licensed party will have the right to attribute the attached testimonial statement (or statements in different words which have substantially the same meaning) to me as an expression of my personal experience and belief.

5. Nothing herein will constitute any obligation on the licensed party to make any rights set forth herein.
6. I further grant to William J. Shelton, DDS., Alexis L. Russell, DDS and Your LifeSmiles the option, exercisable in their sole discretion, to use any filmed or taped performance of me for internet, television and radio commercials on behalf of Advertiser. I understand that my agreements to the terms set herein are not a condition to my employment as a performer in any commercials.

_____ _____

Signature Patient Printed Name

_____

Date