AMERICAN DENTAL SPECIALTY INSTITUTE, S.C.

NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed and how you may gain access to this information. Please review it carefully.

With your consent, we may use your health information for treatment (such as sending your medical record information to a physician as part of a referral), to obtain payment for treatment (such as sending billing information to a health insurance plan), for administrative purposes, and to evaluate the quality of care that you receive (such as comparing patient data to improve treatment methods).

We may use or disclose your identifiable health information without your authorization for several reasons, which are subject to certain requirements. These reasons are workers compensation purposes, and emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may also contact you about appointment reminders or treatment alternatives. In any other situation, we will ask for your written authorization before using or disclosing any of your identifiable health information. If you choose to sign an authorization to disclose information, you may later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post a new notice in the waiting area, and on our Web site.

INDIVIDUAL RIGHTS

In most cases, you have the right to view or obtain a copy of your health information that we use to make decisions about you. If you request copies we will charge you for each page as per provisions under state law. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment and related administrative purposes. If you believe that information in your record is incorrect or if important information is missing you have the right to request that we correct the existing information or add the missing information.

You have the right to request that your health information be communicated to you in a confidential manner such as sending it through the mail to an address other than your home.

You may request in writing that we not use or disclose your information for treatment, payment, or administrative purposes or to persons involved in your care except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

COMPLAINTS

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request, under no circumstance will you be retaliated against for filing a complaint.

OUR LEGAL DUTY

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:

Nancy McGinnis
Privacy Officer
American Dental Specialties Institute
2323 South 109th Street
West Allis, WI 53227
(414) 321-7200

ACKNOWLEDGEMENT

I have read the privacy practices of American Dental Specialties Institute. I also received a copy of the privacy practice for American Dental Specialties Institute.

Signature_____

Date_____

AUTHORIZATIONS

1. I hereby authorize the use or disclosure of my individually identifiable health information to carry out treatment, payment or health care operations.

Signature of patient or patient's representative_____

Date_____

2. I give my permission to ADSI to use personally unidentifiable materials (ie. digital photos, x-rays, and study casts) in presentations to individuals or groups for the purpose of education or demonstration of dental techniques without recourse or compensation.

Signature of patient or patient's representative_____

Date_____