TEXAS
MAXILLOFACIAL
SURGERY
MAZEN DURAINI, DDS, MD

HIPAA Notice of Privacy Practices

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

Protected Health Information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with **Texas Maxillofacial Surgery, PLLC** Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Texas Maxillofacial Surgery, PLLC is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Health Information Rights

Inspect and Copy: You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making any decision about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our practice manager. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Request Amendment: You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request. We will respond in writing within 60 days of your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

The information was not created by us, or the person who created it is no longer available to make the amendment; The information is not part of the record which you are permitted to inspect and copy:

The information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider that the information is accurate and complete.

We will respond within 60 days, in writing, explaining of the request was accepted or denied.

Request an alternative means of confidential communication: You have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, {using a form provided by our practice}, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

Request a restriction of your PHI*:* This means you have the right to ask us, in writing, not to use or disclose any part of your Protected Health Information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction

An accounting of Disclosure: You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will accommodate all reasonable requests.

A Paper copy of This Notice: You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit by calling and asking us to mail you a copy.

File a Complaint: If you believe we have violated your medical information privacy rights, you have the right to file a complaint with us, or directly to the Secretary of Health and Human services.
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Washington, D.C. 20201 1-877-696-6775 www.hhs.gov/ocr/privacy/hipaa/complaints/

Authorize other use and disclosure*:* You have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice, has taken an action in reliance on the use or disclosure indicated in the authorization.
We may contact you to provide information about health-related benefits and services offered by our office, for fundraising activities, share information in a disaster relief situation, include your information in a hospital directory, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Ways in Which We May use and Disclose Your Protected Health Information

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health Information fall within one of these categories.
Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally, we may from time to time disclose your health information to another physician whom we have requested to be involved in your care. For example - we should disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.
Health care operations: We will use and disclose your protected health information to support the business activities of our practice. For example
– we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third-party business associates who perform billing, consulting, or transcription services for our practice.
Payment: We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example - we may include information with a bill to a third- party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Other Ways We May Use and Disclose Your Protected Health Information

Public health*:* We will use and disclose your protected health information in certain situations to help with public health and safety issues. Some of the situations include:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Research: We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law: We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

Other Permitted and Required Uses and Disclosures*:* We are also permitted to use or disclose your PHI without your written authorization for the following purposes:

- To comply with Food and Drug Administration requirements
- Legal proceedings
- Coroners
- Funeral directors
- Organ Donation
- Criminal activity
- Military activity
- National security
- Worker's compensation
- When an inmate is in a correctional facility
- If requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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Texas Maxillofacial Surgery Financial Policy

BASIC POLICY: **Payment is due at the time of services are rendered.** The office will accept the following instruments for payment of services rendered: Visa, Mastercard, Discover, Cash, and Personal Checks with a valid Driver's License. It is our policy to submit any insufficient funds (NSF checks) to an outside check collection agency that will electronically obtain any payments due to our office and a **$30.00 fee will be charged to your account.** If payment has not been made to an account 90 day after service is rendered, and no contact or appropriate arrangements have been made, the account will be referred to the necessary legal authorities.

- To assist our patients, we accept Care Credit. Please ask our office staff for additional information.
  - Care Credit card holder must be present for all transactions.
  - No over the phone payments accepted for Care Credit.

FOR PATIENTS WITH INSURANCE: As a service to our patients, insurance is filed as a courtesy and coverage does not relieve the patient of financial responsibility nor suspend payments until the insurance is paid. Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service, **but the ultimate responsibility for any unpaid balance rest on you.** Please understand that insurance is a contract between you and your insurance company. **If an insurance carrier has not paid within 90 days of billing, any unpaid professional fees are due and payable in full by you. After 90 days of unpaid accounts they will be placed with an outside collection agency. Please be advised to follow up with your insurance company to be sure that they are processing your claim. Any refunds due to overpayment if were processed thru care credit or dental fee plans will have less the service fee.**

- This office will file on primary insurance only. It is the patient's responsibility to file with their secondary insurance. In the event dental insurance carriers require our office to file with the medical insurance first, the patient will be **responsible** for the estimated portion based on **DENTAL** benefits **three days prior to scheduled surgery date.**
- For patients with no insurance, fees will be due and payable **three days prior to scheduled surgery date.**

NON-COVERED SERVICES: Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial. Our office will do no appeals or narratives on your behalf one the claim has been denied for the non-covered services.

PERSONAL INJURY CASES: This office does not accept liens or bill for auto-accident or other liability or lawsuit-related cases. It is the patient's **responsibility and obligation** to pay at the time of service.

FOLLOW UP VISITS/AFTER HOURS: Periodic postoperative office visits may or may not be covered under your insurance plan; however, these may be required by the attending doctor to monitor your health.

CANCELLATION OF APPOINTMENTS: Our goal is to provide high quality of care at low cost to our patients and in fairness to other patients and the doctor; we require 24 hours' notice when canceling an appointment. A reservation cancellation less than 24 hours prior can disrupt the quality time that other patients receive. A cancellation within 24 hours of the scheduled appointment will result in a **$50 deposit** for future reservations. This deposit reservation fee must be paid when securing the subsequent appointment. The deposit will be applied toward the dental care you receive. There is a **$150.00 fee for no call/no show** on surgical cases, which will be due and payable from you. The practice reserves the right to dismiss patients with multiple canceled appointments.

DELINQUENT ACCOUNTS: Should your account become delinquent for nonpayment, you will be reported to the collection service. If you are unable to make your payment in full, please call to make satisfactory payment arrangements. Your account will be subject to **an additional charge of 1.5% interest per month.**

Guarantor / Patient Signature____ Date ________________

ASSIGNMENT OF INSURANCE BENEFITS – Patients with insurance coverage, please read and sign below:

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance and any other health plans to Texas Maxillofacial Surgery, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. **I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.** I hereby authorize said assignee to release all information necessary to secure the payment. I also acknowledge that if my claim is not processed in **45 days that it becomes my responsibility.**
I have read, understood and agree to the above financial policy for payment of the professional fees. I understand that I am ultimately responsible for all fees for service provided to me.

Guarantor / Patient Signature____ Date ________________

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HIPAA POLICY AND FINANCIAL POLICY ACKNOWLEDGEMENT

By signing this form, I ________________________ acknowledge you received a copy of the
Print Patient Name
HIPAA Notice of Privacy Practices. Our HIPAA Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change.

____ _______________
Signature of Patient/Responsible Party Date

By signing this form, I _________________________ acknowledge you received a copy of the TXMFS
Print Patient Name
Financial Policy. Our Financial Policy is subject to change. We encourage you to read it in full.

____ _______________
Signature of Patient/Responsible Party Date

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our HIPAA Privacy Policy and Financial Policy, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other ____
- ☐

Witness________________________________ Date_______________

OFFICE USE ONLY

Witness________________________________ Date_______________

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