Nicolas Nieto D.M.D., PA

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.

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 *April 14, 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 the Notice, please contact us using the information listed at the end of this Notice.

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 and disclose your health information to obtain payment for services we provide to you.

HealthCare Operations: We may use and disclose your health information in connection with our health care in connection with our healthcare operations. HealthCare operation include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditations, 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 cannot 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 to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter-intelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information or inmate or patient under certain circumstances.

Appointment Reminders: We may use or 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 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. 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 $0.50 for each page, $10. per hour for staff time to locate and copy your health information, and postage if you want the 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.)

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 6 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.

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 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 it must explain 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.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have 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 also submit a written complaint to the U.S. Department of Health and Human Services upon request.
We support

Huntington Dental Arts
Huntington Office Park
Safety Harbor, FL 34695

FINANCIAL AGREEMENT

We have found that a clear agreement on finances BEFORE treatment begins results in fewer misunderstandings. With that in mind, we have carefully developed the following financial information. Please read and understand the following regarding payment of dental fees. At the end of this document, you will be asked to sign in agreement and understanding of this document. You will be provided a copy for your records if requested.

ESTIMATES

It is to everyone's advantage that our patients be as completely informed as possible. Therefore, it is our policy to provide a Treatment Plan with estimated fees ***before*** any work begins. All estimates are guaranteed for 90 days only. Please understand an estimate is just that . . . an estimate. We try to carefully plan all treatments, but during the course of a treatment, additional, alternative or more costly treatment may become necessary. We will, of course, inform you of such an event before continuing.

PAYMENT METHODS

We accept case, personal checks, money orders, traveler's checks, Discover, MasterCard and Visa. We do ***not*** accept American Express at this time. For treatments over $1,000., financing is available through Care Credit, pending approval.

ARRANGEMENTS

For all Non-Insured / Non-Financed patients, all services are ***PAYABLE IN FULL AT TIME OF TREATMENT.*** As an incentive, we offer a 5% discount for any services totaling $1000. or more if payment is ***made in full*** by ***CHECK or CASH ONLY. Credit Cards are excluded from this incentive.*** This offer is good for up to 30 days after Treatment Plan is presented.

BROKEN / CANCELLED APPOINTMENTS

Missed appointments are a loss for everyone! Please understand that when an appointment is made, that time is reserved especially for you alone. If your appointment is broken or cancelled 48 hours prior to the appointed time we find it necessary to ***charge a fee equal to the fee allotted to that appointment time***. Our practice does not double-book patients as in high-volume offices. Emergencies permitting, Dr. Edwards desires to spend treatment time exclusively with you at your appointment.

CONCERNING INSURANCE

Insurance coverage is a CONTRACT BETWEEN THE PATIENT AND THE INSURANCE CARRIER. It is a benefit to the patient and should be considered only an adjunct to dental treatment. It does NOT and never was INTENDED to pay for all of your dental treatment. As a convenience to our patients, we will file your insurance claims with your carrier. We will determine from your insurance company the amount of coverage for your procedure. You will be responsible for payment of your co-insurance and deductible amount.

The following information is required to process your claims:

- Dental Insurance carrier name and address.
- Dental Plan Name.
- Dental Group Number.
- Employer name and address.
- Second plan information. (Note: When two carriers are involved, it is REQUIRED to disclose the double coverage information to BOTH carriers.

OTHER CHARGES

There is a $35.00 charge for ALL returned checks.

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It is our sincere intention to provide the best dental care available at the most reasonable fees. Also, we hope that by providing you with the above information, no misunderstandings will arise as we proceed with your treatment. Please feel free to ask questions or make suggestions. My staff and I will assist you in any way possible.

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I have read, understand and agree with the above information.

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Patient / Responsible Party Witness Date