STILLWATER DENTAL
WELLNESS CENTER

James E. Telloian, DDS
1930 Black Lake Blvd. SW
Olympia, WA 98512
(360) 352-0847

STATEMENT OF PRIVACY PRACTICES

We, at Stillwater Dental Wellness Center, are dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee is to ensure that your health information is ever compromised. This is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION-

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Washington. This includes issues relating to your treatment, payment, and our dental care operations. Your Personal Health information will never be given to anyone-even family members-without your written consent.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is protected. Our privacy practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION-

We will only request personal information needed to provide our standard of quality dental care, implement payment policies, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION-

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards. We may use information provided by you for implementation of payment policies. Be assured, all communication will be as protective of your privacy rights as possible.

PATIENT RIGHTS-

You have the right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient in our care. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

James E. Telloian D.D.S.
STILLWATER DENTAL WELLNESS CENTER

STILLWATER DENTAL
WELLNESS CENTER

James E. Telloian, DDS
1930 Black Lake Blvd. SW
Olympia, WA 98512
(360) 352-0847

Acknowledgement of Receipt of Notice of Privacy Policies

I acknowledge that I have received a copy of the notice of Privacy Practices for the offices of James Telloian, DDS at STILLWATER DENTAL WELLNESS CENTER. The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of the office's health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

James Telloian, DDS reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices. If Privacy Practices change, I will be offered a copy of the revised practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby authorize disclosure of my protected health care information to the persons indicated below:

ANY MEMBER OF MY IMMEDIATE FAMILY	_____Yes	_____No
SPOUSE ONLY	_____Yes	_____No
OTHER (PLEASE SPECIFY)	_____Yes	_____No

_____ _____
Name of Patient Signature of Patient or Personal Representative

_____ _____
Date Description of Personal Representative's Authority

Office Use Below This Line

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED

Provided prior to treatment? _____Yes _____No

Date Provided _____

Reason for Denial:
_____Needed more time to review Notice of Privacy Practice
_____Wanted to consult with another person before signing
_____Unable to sign
_____Reason given for not signing (explain)