Sachi and Co. Dentistry

Notice of Privacy Practices

This notice describes how your health information 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

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this notice about our office's privacy practices, our legal duties and your rights regarding your health information. We are required to follow the practices that are outlined in this notice while it is in effect. This notice takes effect July 1, 2019 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 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. For more information about our privacy practices or additional copies of this notice, please contact us (contact information below).

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment and health care operations.
For example:

Treatment
We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment
We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Health Care Operations
We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization
In addition to our use of your health information for treatment, payment or health care 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 is 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.

Persian (Farsi):

Russian:

5676 89: ;69:<:=>?@8A6B A<>C>A6 D@8E<69C: EF@G:896H<B@9 A<>@C96 ; , A:9:F I @ C@ G:8969:?C: J:F:7 : =:H:FB9 C6 6C=<>K8A: ; BL I A@, M8<M=> E@F@H:G?>A6, ?9:D I E: ; :?N > ; :D8MG>9N EF@G:896H<B@ ; MO C6 ; > 89: ;69:<:=>?@8AMO E: ; : PN.

Japanese:

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lǵnZ

Arabic:

Hmong:

Ang aming pagsasanay ukol sa ngipin o dental practice ay magbibigay ng libreng mga serbisyong tulong sa mga indibiduwal na hindi masyadong nakakapagsalita ng Ingles upang talakayin ang pangangalaga sa ngipin na aming ibinibigay.

Hindi:

बारेमें उसकेहै रहे कर रदान देखभाल चिकि ा दंत जो हम ,उनको है सकते नही बोल ईंगलीश तरह अ ी वयकती जो , रभारी केचिकि ालय दंत हमारे करेंगे रदान सेवाएं सहायता भाषा फ़ीस कोई बीना लिये करनेके बात |

Thai:

แนวปฏิบัติด้ านทันตกรรมของเราจะให้ บริการช่ วยเหลือด้ านภาษาฟรีแก่ บุคคล พูดภาษาอังกฤษไม่
นาญเพียงพอ จะหารือเกยวกับบริการทันตกรรมของเรา

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this Acknowledgment

I__________________________________ [full name] have received a copy of the ________________________________ [name of practice] Notice of Privacy Practices.

Print Name ____________________________________

Signature _____________________________________

Date ________________________

If this acknowledgment is signed by a personal representative on behalf of the patient, complete the following:

I_________________________________ [full name] have received a copy of the _____________________________ [name of practice] Notice of Privacy Practices.

Personal Representative's name_________________________________

Relationship to Patient____

For Program Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ▫ Individual refused to sign
- ▫ Communications barriers prohibited obtaining the acknowledgement
- ▫ An emergency situation prevented us from obtaining acknowledgement
- ▫ Other (Please Specify)