BLOOM & BLOOM
The Center for Excellence in Dentistry

815 LIVINGSTON AVE, NEW BRUNSWICK NJ 08901

732.249.6386
FRONTOFFICE@BLOOMANDBLOOMNJ.COM

HIPAA 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. This Notice provides you with information to protect the privacy of your confidential health care information, hereafter referred to as protected health information (PHI). The Notice also describes the privacy rights you have and how you can exercise those rights.

Please review it carefully. If you have any questions about this Notice, please contact our office at 732-249-6386 or frontoffice@bloomandbloomnj.com

OUR COMMITMENT REGARDING YOUR PERSONAL HEALTH INFORMATION

Bloom and Bloom DMD's is committed to maintaining and protecting the confidentiality of our patients personal information. This Notice of Privacy Practices applies to Bloom and Bloom DMD's doctors, clinical staff,employees, Business Associates (outside contractors hired), their subcontractors, health benefits plans, dental plans, employee assistance plans (EAPs) and pharmacy benefit programs. The Plans are required by federal and state law to protect the privacy of your individually identifiable health information and other personal information. We are required to provide you with this Notice about our policies, safeguards and practices. When the Plans use or disclose your PHI, the Plans are bound by the terms of this Notice, or the revised Notice, if applicable.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our Office.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you (Health Information). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the dental care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your dental plan) for their dental care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project

will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers Compensation. We may release Health Information for workers compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the persons agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that persons involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES
The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer

disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you-revoked it will not be affected by the revocation.

YOUR RIGHTS:
You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records. To inspect and copy this Health Information, you must make your request, in writing, to our Privacy Officer. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend.

For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us out-of-pocket, in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.bloomandbloomdmds.com, under the Practice Info link. To obtain a paper copy of this notice, please contact our Office

TELEPHONE CONTACT, MESSAGES AND EMAIL

From time to time, Bloom and Bloom DMD's may need to contact you regarding the treatment we provide to you. If contacting you by telephone, we may leave a voicemail or message if you have given us permission to do so on the form you sign acknowledging receipt of this Notice. We may also use email to contact you if you have given permission on the acknowledgement form.

FOR MORE INFORMATION

If you have questions or would like additional information, please contact our Privacy Officer at 732-249-6386. If you believe your privacy rights have been violated, you can file a complaint with our office.

Complaints may be addressed to:

Dr. Gari Bloom DMD, Privacy Officer
815 Livingston Avenue
New Brunswick, NJ 08901

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services using the contact information provided below. There will be no retaliation against you for filing a complaint.

File a Complaint Using the Health Information Privacy Complaint Form Package

Open and fill out the Health Information Privacy Complaint Form Package - PDF https://www.hhs.gov/sites/default/files/ocr-hip-security-complaint-form-package.pdf in PDF format. You will need Adobe Reader software to fill out the complaint and consent forms. You may either:

Print and mail the completed complaint and consent forms to:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

Email the completed complaint and consent forms to OCRComplaint@hhs.gov (Please note that communication by unencrypted email presents a risk that personally identifiable information contained in such an email, may be intercepted by unauthorized third parties)

To File A Complaint Without Using the Health Information Privacy Complaint Package

If you prefer, you may submit a written complaint in your own format by either printing, completing and mailing to the above address and/or email to OCRComplaint@hhs.gov

Be sure to include: Your name, full address, telephone numbers (include area code), e-mail address (if available), name, full address and telephone number of the person, agency, or organization you believe violated your (or someone else's) health information privacy rights or committed another violation of the Privacy or Security Rule, a brief description of what happened. How, why, and when do you believe your (or someone else's) health information privacy rights were violated, or how the Privacy or Security Rule otherwise was violated, any other relevant information and your signature and date of complain.

If you are filing a complaint on someone's behalf, also provide the name of the person on whose behalf you are filing. You may also include: If you need special accommodations for us to communicate with you about this complaint, the contact information for someone who can help us reach you if we cannot reach you directly, and if you have filed your complaint somewhere else and where you've filed

EFFECTIVE DATE

This Revised Notice is effective April 3 2024

BLOOM & BLOOM
The Center for Excellence in Dentistry
815 LIVINGSTON AVE, NEW BRUNSWICK NJ 08901
732.249.6386
FRONTOFFICE@BLOOMANDBLOOMNJ.COM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign this Acknowledgement *

By signing below I am acknowledging that:

I (**PLEASE PRINT PATIENT'S FULL LEGAL NAME**) _____ have received a copy of *Bloom and Bloom DMD's* **Notice of Privacy Practices** and have been offered a copy of such policy to keep for my records**.** I also give my consent to share my/the patient's health related information with the following people (please list all whom apply):

_____

_____

Please place a check mark below to note we may leave you a message if needed:

☐ ***voicemail on cellphone*** ☐ ***voicemail on home phone*** ☐ ***text message*** ☐ ***voicemail on office phone*** ☐ ***email***

Print Patient Name:_____

Patient's Signature:_____

Date:_____

If you completed and/or signed this form on behalf of the patient please **Print YOUR Name & RELATION to Patient** (Parent/Guardian/Caretaker...)

_____

_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement 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)

_____

_____

_____

BLOOM & BLOOM
The Center for Excellence in Dentistry

815 LIVINGSTON AVE, NEW BRUNSWICK NJ 08901
732.249.6386
FRONTOFFICE@BLOOMANDBLOOMNJ.COM

Authorization and Consent to Transmit Unencrypted Patient Information Electronically

Until I inform you in writing to stop, I authorize Bloom & Bloom DMD's to transmit patient information relating to my treatment, health, or payment electronically, without encryption or special security precautions, to me or someone I designate, or to other health care providers, insurance plans and others involved in my treatment, payment for my treatment, or Bloom & Bloom DMD's health care operations. The patient information that may be transmitted may include my x-rays, health history, diagnosis, treatment and payment records.

I understand that:

- Bloom and Bloom DMD's does not email such sensitive personal information as social security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign the form, Bloom & Bloom DMD's may use other ways to send my information, such as US Mail, or may ask me to send my information to third parties myself.
- There is some risk that electronic messages may be improperly acquired or received by unintended recipients. If that happens the information may be redisclosed and no longer protected by privacy law. Bloom & Bloom DMD's has never experienced a breach in electronic security however, should it occur I will be notified immediately if they learn of such a breach. Bloom and Bloom DMD's computers are all password protected and the WiFi they use to transmit patient information is locked and not available to the public.
- I do not have to sign this form.
- I can tell you in writing to stop transmitting patient information at any time, but if I do so, this will not affect transmissions that Bloom & Bloom DMD's already sent before receiving my written instructions to stop.

Bottom line: I give Bloom & Bloom DMD's permission to continue to send and receive my patient information electronically without encrypting it. They have worked with computer professionals and have taken great pains to be sure that their electronic system is secure; it has never been breached.

Patient or Guardian Name (please print and note relation to patient):

_____

Patient or Guardian Signature: _____

Date (MM/DD/YYYY) _____