Dr. Holly Pickrell Dr. Misty Brey-Sanford Dr. Payton Sanford

Notice of Privacy Practice

~ This notice takes effect February 16, 2026~

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment, and health care operations.

***TREATMENT** means providing, coordinating, or managing health care and related service by one or more health care providers. Examples of treatment would include: crowns, fillings, prophy, etc.

***PAYMENT** means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities. Examples of this would be collecting and billing your insurance company.

***HEALTH CARE OPERATIONS** include the business aspects of running our practice, such as conducting quality assessment and improving activities, auditing functions, cost management analysis, and customer service

***SUD TREATMENT INFORMATION** If we receive any information about you from a substance use disorder treatment program that is covered by 42 CFR part 2 through a general consent you provided to the program we will use this information for treatment purposes, payment or health care operations purposes as describes in this notice. We will not use or disclose records, or testimony that describes this information in any civil, criminal, administrative, or legal proceeding by any Federal, State or local authorities against you, unless it is court ordered.

In addition, your confidential information may be used to remind you of appointments or provide you with information about treatment options via phone or mail. We will use and disclose your information

when required by law, or requested by public health authorities for collecting information which may include: response to court order, involvement in lawsuit, response to a discovery report, subpoena, or other lawful process but only if we have made effort to inform you of the request.

We may disclose your PUBLIC HEALTH INFORMATION if requested by:

Law enforcement, medical examiner or coroner, funeral director, organizations that handle organ donations, government authorities, federal authorities, national securities, and workers compensation.

We may also disclose your information when necessary to reduce or prevent a serious threat to your health and the safety of others. We will only disclose this information to the person or organization able to prevent this threat.

Any other uses or disclosure will be made only with your written authorization. You may revoke such authorizations in writing and we are required to honor and abide by this request, except to the extent that we have already taken actions.

You have rights in regards to your **PROTECTED HEALTH INFORMATION**

This may include the limit of information to family members or any person identified by you as well as confidential communication by other means via mail or phone

right to access, inspect your information, or obtain a copy at any time

right to request an amendment to your information

right to receive an accounting of disclosure of your information outside of treatment, payment and health care operations

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and proved you of our legal duties and privacies with respect. We are required to abide by the current effective terms. We reserve the right to change these terms and make the new notice effective for all information we maintain. The revision will be posted on the effective date and you will receive an updated version.

You have the right to file a formal written complain to our office, the Department of Health and Human Services, or the Office of Civil Rights in an event that you feel your privacy rights have been violated.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I have received a copy of this office's NOTICE OF PRIVACY PRACTICES

_____

Print name

_____ _____

SIGNATURE Date

Who we can disclose information to: (please provide name)

_____

☐ PLEASE DO NOT DISCLOSE MY INFORMATION UNLESS REQUIRED

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgment but could not obtain due to:

☐ individual refusing to sign

☐ communication barrier

☐ emergency situation preventing us from obtaining

☐ other (please specify)

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FINANCIAL POLICY

Thank you for choosing Dr. Pickrell and Dr. Brey-Sanford for your dental care. Your dental health is our priority. Of course, with any business we must reconcile our financial relationship as well. Patients have access to a variety of dental plans, and our financial relationship is dictated by the dental plan you chose. Many of you have selected plans that have deductibles and copayments it is our responsibility to collect those fees at the time the service is rendered. Our contract with your insurance requires us to make these collections. We appreciate your cooperation with our staff in this regard. If you have any questions about this process please contact your insurance company.

PAYMENT: Payment is due in full at time of service. Deductibles and copays well be collected at time you check out of the office.

INSURANCE: We file your insurance claim as a courtesy and not the responsibility of the office. Ultimately finances incurred are the responsibility of the patient. Should your insurance company deny your claim or not respond to our collection efforts, payment will be expected by patient. It is your responsibility to provide the office with accurate insurance information as well as changes that occur.

UNPAID BALANCES: A fee of $25.00 will be assessed on any checks returned or not honored by your bank. This will be due IN CASH CURRENCY when you come into the office to retrieve original check. All unpaid balances will acquire a billing charge after 30 days of no activity on account.

COLLECTION ACCOUNTS: In the event that the account is release to a collection agency, you agree to pay all of collection cost which includes court cost and attorney fees.

MISSED APPOINTMENTS: We ask that you cancel or reschedule your dental appointment with a 24-hour notice. Failure to do so will result in a $25.00 charge to your account. If you arrive more than 15 minutes late to your appointment, we will ask you to reschedule in consideration for our other patients.

I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

SIGNATURE **DATE**