NOTICE OF PRIVACY PRACTICES

Effective Date: 03.21.2023

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 references to "Abra Health Practice" and "Abra Health Professionals" in this notice refer to the members of Abra Health Affiliated Covered Entity (the "ACE"). An Affiliated Covered Entity is a group of organizations under common ownership or control who designate themselves as a singled Affiliated Covered Entity for purposes of compliance with the Health Insurance Portability and Accountability Act (HIPAA). Abra Health Practice, its employees, workforce members and the members of the ACE who are involved in providing and coordinating dental services are all bound to the follow the terms of this Notice of Privacy Practices (NPP). The members of the ACE will share PHI with each other for treatment, payment and health care operations of the ACE as permitted by HIPAA and this NPP. For a complete list of the members of the ACE, please contact the Privacy Officer.

The ACE also participates in an Organized Health Care Arrangement (OHCA) with other dental practices, medical practices, and other health care providers and suppliers. An OHCA is an arrangement or relationship recognized in the HIPAA privacy rules that allows two or more covered entities who participate in joint activities to share the PHI about their patients to manage and benefit their joint operations. The Abra Health Organized Health Care Arrangement (Abra Health OHCA) will share PHI with its participants in the OHCA for treatment, payment, and health care operations of the OHCA.

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION AND TO PROVIDE YOU WITH A NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION. PROTECTED HEALTH INFORMATION IS INFORMATION ABOUT YOU, INCLUDING DEMOGRAPHIC INFORMATION THAT MAY IDENTIFY YOU AND THAT RELATES TO YOUR PAST, PRESENT OR FUTURE PHYSICAL OR DENTAL HEALTH OR CONDITION AND RELATED HEALTH CARE SERVICES.

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION:

1. Inspect and copy all or any part of your dental or health record, as provided by federal regulations.

2. Request restrictions on the use and disclosure of your PHI. However, the ACE is not required to agree to the restriction, except if you pay for a service entirely out-of-pocket. If you pay for a service entirely out-of-pocket, you may request that information regarding the service be withheld and not provided to a third-party payor. The ACE is obligated by law to abide by such restriction. If you wish to request a restriction on the use and disclosure of your PHI, please provide a written request describing your requested disclosure to the Privacy Officer. We will notify you of our decision regarding the requested restriction.

3. Request that we amend your dental record, to the extent that such amendments are permissible under federal regulations.

4. Request and receive an accounting of disclosures made of your health information, except for disclosures made for the purpose of treatment, payment, health care operations and certain other purposes if such disclosures were made through a paper record or other health record that is not electronic, as set forth in federal regulations. If you request an accounting of disclosures of your PHI, the accounting may include disclosures made for the purpose of treatment, payment, and health care operations to the extent that disclosures are made through an electronic health record.

5. Obtain a paper copy of this Notice from the ACE upon request.

6. Receive communications regarding your health information by alternative means or have such communications addressed to an alternative location. For example, at your request, we will mail items to a post office box instead of your residence.

7. Receive notification if your unsecured (i.e., identifiable) PHI has been accessed by unauthorized individuals if we determine that there is a potential risk of harm because of the unauthorized access.

9. If you execute any authorization(s) for the use and disclosure of your health information, revoke such authorization(s), except to the extent that action has already been taken in reliance on such authorization.

10. Request and receive an electronic copy of your PHI if the ACE maintains your PHI in an electronic health record. The ACE may charge you a reasonable fee to cover its costs for this service.

11. Right to revoke your authorization. You may revote any authorization you sign with the ACE, except to the extent the Facility or Dental Health Professional have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Officer identified below.

WE MAY DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION FOR THE FOLLOWING REASONS:

1. We may disclose your PHI for the purpose of treatment, payment, or health care operations. Examples of these types of disclosures are provided below:

   Treatment purposes

   Example: Treatment means providing, coordinating, or managing dental care services and may include crowns, fillings, teeth cleaning services and other procedures. Information obtained by your dentist will be recorded in your dental record and used to assess and monitor your dental health status, determine the appropriate care and treatment for you, and undergo cleanings, treatment, and procedures for you, as necessary.

   Payment purposes

   Example: Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. A bill may be sent to you or to a third-party payor. The information on the bill or accompanying the bill may include information that identifies you, your treatments rendered to you, and the supplies and equipment used to perform the treatments.

   Health care operations

   Example: Health care operations include the business aspects of running our practices, such as conducting quality assessments and improvement activities, auditing functions, cost-management analysis and customer services. Employees of the ACE and its staff may use information in your dental record to assess the quality of the care and treatment they provide to you. The information will then be used to continually improve the quality and effectiveness of the dental care and services that we provide to all our patients.

2. We may disclose your PHI to inform you of treatment alternatives, or other health-related benefits.

3. We may contact you to provide appointment reminders. In some instances, as required by law, we may seek your consent prior to providing you with certain materials.

4. We may disclose your PHI for the purpose of research. We will only disclose your PHI for research purposes without your express authorization if the research protocol has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

5. We may disclose your PHI to public health officials.

6. We may disclose your PHI to law enforcement officials for law enforcement purposes.

7. We may disclose your PHI to an appropriate governmental authority if we reasonably believe that you may be a victim of abuse, neglect, or domestic violence.

8. If we believe it is necessary to avert a serious threat to the health or safety of yourself or the public, we may disclose your PHI to a person or persons who we believe are reasonably able to prevent or lessen the threat.

9. We may disclose your PHI as a source of data for business planning and for certain marketing purposes.

10. We may use your PHI as a tool for quality assurance and continuous quality improvement.

11. We may disclose your PHI as required by federal and state laws and regulations.

12. We may disclose your PHI to a health oversight agency, such as State Health Services, state Human Services Commissions or the United States Department of Health and Human Services for purposes relating to the oversight of the health care system and government benefit programs such as Medicare or Medicaid.

13. We may disclose your PHI during a judicial or administrative proceeding in response to a court order, subpoena, discovery request or other lawful process.

14. We may disclose your PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other purposes as authorized by law. We may also disclose your PHI to funeral directors as necessary to carry out their duties.

15. If you are a member of the United States or foreign Armed Forces, we may disclose your PHI for activities that are deemed necessary by appropriate military command authorities to assure the proper execution of a military mission.

16. We may disclose your PHI to authorized federal officials for the conduct of lawful intelligence, counterintelligence and other national security functions authorized by law, or for the purpose of providing protective services to the President or foreign heads of state.

17. We may disclose your PHI to a correctional institution or a law enforcement official having lawful custody of you.

18. We may disclose your PHI as authorized by, and in compliance with, laws relating to workers' compensation and similar programs established by law that provide benefits for work-related illnesses and injuries without regard to fault.

19. We may use and disclose PHI to organ, eye or tissue procurement and transplantation if you are an organ donor.

EXAMPLES OF OTHER PERMISSIBLE OR REQUIRED DISCLOSURES

Business associates: Some activities of the ACE are provided on our behalf through contracts with business associates. Examples of when we may use a business associate include billing and coding audits performed by an outside auditor, and other legal and consulting services provided in response to billing and reimbursement issues which may arise from time to time. When we enter contracts to obtain these services, we may need to disclose your health information to our business associate so that the associate may perform the job which we have requested. To protect your health information, however, we require our business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, close friend, or other person responsible for your care of your location and general condition. **The ACE will not disclose your PHI to your family members, personal representative or close personal friends as described in this paragraph if you object to such disclosure. Please notify the Privacy Officer at the number provided below if you object to such disclosures.**

Communication with family members: Health professionals, including those employed by or under contract with the ACE may disclose to a family member, other relative, close friend, or any other person you identify, health information relative to that person's involvement in your care or payment related to your care, unless you object to the disclosure.

Federal law allows for the release of your PHI to appropriate health oversight agencies, public health authorities or attorneys, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Any use or disclosure of your PHI that is not listed above will be made only with your written authorization.

ACE GROUP'S RESPONSIBILITIES

1. Maintain the privacy of your dental information.

2. Provide you with this Notice as to our legal duties and privacy practices with respect to the information we maintain and collect about you.

3. Abide by the terms of this Notice.

4. Notify you if we are unable to agree to a requested restriction.

5. Provide you with a revised copy of this Notice if it is altered or amended.

6. Notify you if we discover a breach of any of your PHI that is not secured in accordance with federal guidelines.

7. Notify another covered entity if we inadvertently receive your PHI from a covered entity or a business associate thereof because of a breach of your PHI. In addition, we will return or destroy such protected health information to the extent required by law.

The ACE reserves the right to change its privacy practices for all protected health information that we maintain. If our privacy practices materially change, the ACE will revise this Notice and make this Notice available to you the next time you visit our office. If you request for us to do so, we will mail you a copy of this Notice. In addition, this Notice is available on our website at www.abradental.com and www.abrahealth.com.

Unless you authorize us to do so, the ACE will not use or disclose your personal health information in a manner inconsistent with this Notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer. Additionally, you may file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation against you for filing a complaint.

If you have questions or would like additional information regarding this Notice of Privacy Practices, the ACE, or the OHCA, or if you wish to file a complaint with us regarding our use or disclosure of your PHI, you may contact the ACE's Privacy Officer, Dr. Kevin Reilly (973)536-0607 or kreilly@abrahealth.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, I acknowledge receipt of the Notice of Privacy Practices of the Abra Health Affiliated Covered Entity (the "ACE"). The Notice of Privacy Practices provides information about how the ACE may use and disclose my protected health information.

I acknowledge receipt of the Notice of Privacy Practices of the ACE.

_____ Date:_____

(patient/parent/conservator/guardian)

FOR the ACE USE ONLY

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the patient's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____
_____
_____
_____
_____

Signature of ACE representative:_____

Date:_____